CIVIL ACTION NUMBER 5:96CV91

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

THE STATE OF TEXAS
VS
THE AMERICAN TOBACCO COMPANY; R.J. REYNOLDS TOBACCO COMPANY; BROWN & WILLIAMSON TOBACCO CORPORATION; B.A.T. INDUSTRIES, P.L.C.; PHILIP MORRIS, INC.; LIGGETT GROUP, INC.; LORILLARD TOBACCO COMPANY, INC.; UNITED STATES TOBACCO COMPANY; HILL & KNOWLTON, INC.; THE COUNCIL FOR TOBACCO RESEARCH - USA, INC. (Successor to Tobacco Institute Research Comittee); and THE TOBACCO INSTITUTE, INC.

VIDEOTAPED

ORAL DEPOSITION

OF

PERCY E. LUECKE, JR., M.D.

July 25, 1997

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ANSWERS AND DEPOSITION OF PERCY E. LUECKE, JR., M.D., produced as a witness at the instance of the Plaintiff, taken in the above-styled and numbered cause on the 25th day of July, 1997, at 9:00 o'clock a.m. before Amy Doman, a Certified Shorthand Reporter in and for the State of Texas, at the offices of Jones, Day, Reavis & Pogue, located at 2001 Ross Avenue, 2300 Trammell Crow Center, in the City of Dallas, County of Dallas, State of Texas in accordance with the agreements hereinafter set forth.

A P P E A R A N C E S

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APPEARING FOR THE PLAINTIFF

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Also Present: Mr. Brian K. James, Videographer

P R O C E E D I N G S

MR. BLEVINS: My understanding is that all objections except for privilege are reserved and that one objection is good for all. There's just three of you.

MR. MINTON: Yeah, I will make all the objections. Has there been some order or stipulation or something?

MR. BLEVINS: Eastern District of Texas Rules only allow objections during the deposition based solely on privilege. No other objections are allowed. All others are assumed preserved until trial.

MR. MINTON: So there's a stipulation or rule that says --

MR. BLEVINS: There's a rule in the Eastern District of Texas that requires that. And there's a hot line that --

MS. LEWIS: Court rules.

MR. BLEVINS: Yeah, court rules. And there's a lot line directly to, well, Judge Radford in this case --

MR. MINTON: Uh-huh.

MR. BLEVINS: -- if that's not --

MR. MINTON: Okay. But, in other

words, an objection to the form of a question not made is not waived is what you're saying?

MR. BLEVINS: That is correct. That is correct.

Like I said, this is the fourth one this week, and there has not been a single objection made in any deposition by any attorney. I just give you that as an example, because there's nothing privileged in anything that we're talking about in this particular situation.

MR. MINTON: I will take you at face value. You seem like an honest, straightforward, trustworthy plaintiff's lawyer.

MR. BLEVINS: Sort of an oxymoron, isn't it? No, that is the way they are.

THE VIDEOGRAPHER: We're on the video record.

(No omissions.)

PERCY E. LUECKE, JR., M.D.,

the witness hereinbefore named, being of lawful age and being first duly cautioned and sworn in the above cause, testified on his oath as follows:

EXAMINATION

BY MR. BLEVINS:

Q Good morning, Dr. Luecke.

A Good morning, sir.

Q Would you please state your full name for the record, please?

A My name is Percy Edgar Luecke, Jr., M.D.

Q Dr. Luecke, my name is Bryan Blevins, and I'm here today representing the State of Texas in a Medicaid recoupment case against the tobacco industries. Do you understand the nature of the cause of action and why we're here today?

A I do.

Q All right. Doctor, prior to your deposition today, we were provided with a number of documents by defense counsel, which I have had marked, and I would like to go through very briefly for identification purposes.

A Yes.

(Deposition Exhibit 1 was marked.)

Q Exhibit 1 to your deposition is the final report that we were provided regarding your opinions in this case; is that correct, sir?

A That's correct.

MR. MINTON: May I see it?

MR. BLEVINS: Sure.

(Deposition Exhibit 2 was marked.)

Q (By Mr. Blevins) Exhibit 2 to your deposition is a curriculum vitae or resume of your education, background, associations, and work history; is that correct, sir?

A This is correct.

(Deposition Exhibit 3 was marked.)

Q Exhibit Number 3 to your deposition is a statement which indicates documents on which Dr. Percy Luecke, Jr., relies in forming his opinions. And, sir, the answer to that is none; is that correct?

A None.

Q All right. Now, today you have brought some additional information with you as part of your file; is that correct?

A Yes.

09:16 Q All right. And I think we talked briefly off the record that these are articles that were provided to you by the tobacco industry through the lawyers?

09:16 A These were provided to me by the lawyers, yes, as documents that they had read regarding this particular area that I have been asked an opinion about.

Q Did you, yourself, personally review

09:16 those articles?

A I did.

Q Do those articles in any way form or shape your opinions in this particular case?

A They do not.

09:16 Q They do not? Okay. Doctor, we're going to mark those in a few moments as an additional exhibit to this deposition, and then I will have you identify those documents, but I don't anticipate going into any depth in them, all

09:17 right?

A (Witness nods.)

(Deposition Exhibit 4 was marked.)

Q The next Exhibit to your deposition is

09:17 Exhibit Number 4, which is entitled List of Cases

Since 1994 in which Expert has Testified by Deposition or at Trial. And, again, the answer was none?

A None, correct.

Q And, Doctor, is that correct? Have you provided any testimony?

A Correct, no.

(Deposition Exhibit 5 was marked.)

Q Okay. The final exhibit or another exhibit to your deposition today, Deposition Exhibit Number 5, is entitled List of all Books, Articles, or Papers Authored in Whole or in Part by Expert. And the answer there, sir, was, "Will supplement." Is that correct?

A Yes.

Q Okay.

A I provided a -- an article that I wrote, coauthored in 1960 called ABO Isoimmunization, Journal of Pediatrics, April 1960.

Q Okay. Doctor, is this the only article or publication that you have participated in in your medical career?

A This is the only one that I have

participated in in my medical career --

Q Okay.

A -- in a formal medical journal.

Q Okay. Did this particular article have any relevance to the issues that we're talking about today, predominantly tobacco smoke and its impact, maternal smoking and its impact upon the fetus?

A Did not.

Q Have you ever participated either in a formal publication or an informal publication such as health bulletin, committee paper -- I'm trying to think of some other examples -- an abstract, a book review, other forms of research and publication on the issues of tobacco, maternal smoking, and injury to the fetus?

A Not in a formal way, no.

Q Okay. Doctor, when were you first contacted regarding providing testimony on behalf of the tobacco industry in this case?

A I was contacted probably in middle or latter part of March by Dr. Cole.

Q That would be March of this year?

A Yes, sir, March of 1997.

Q Had you known Mr. Cole, who as I

09:19 understand, is here today representing Lorillard Tobacco Company, had you known Mr. Cole prior to this time?

A Dr. Cole and I were medical students together at Washington University in St. Louis.

Q And to your knowledge, is Mr. Cole an attorney as well as a medical doctor?

A Yes, to my knowledge.

Q Okay. Did you then continue that association after medical school with Dr. Cole?

A No. Dr. Cole went into surgery and practiced in Missouri for many years. And then I went into pediatrics and returned to Dallas.

Q Prior to his contacting you in March of 1997, had you had any professional relationship or association with Dr. Cole since your time in med school?

A No.

Q At the time that you were contacted in regards to this case, were you given a description about the case, what it included, and what the tobacco industry was interested in you expressing opinions on?

A As I recall the conversation, Dr. Cole gave me an overview of what it was and, also, that

they were interested in a practicing pediatrician who saw patients on an individual basis and an opinion that might be of information to them in that case.

Q In that original conversation, did the issue of your testifying at trial or at a deposition, was that topic broached?

A Not at that conversation, no.

Q Can you give me any specifics, based upon your recollection, of the overview that Dr. Cole provided you about this case?

A Recollection that they -- there was a case instituted by the State of Texas attempting to get Medicaid reimbursement in relation to tobacco and possibly what was called tobacco-related illnesses.

Q Okay. Doctor, understanding that your area of practice of medicine has been in the area of pediatrics, during this overview, did Dr. Cole discuss with you or inquire about your opinions in regards to the relationship of smoking and other illnesses outside the area of pediatrics?

A No, to my recollection.

Q At that time did you express to him any opinions regarding your knowledge or

09:22 1 understanding of smoking and other illnesses
2 outside the area of pediatrics?
3 A Not at that conversation, no. The
4 conversation was an initial contact to ask if I
09:22 5 might be available or interested in this general
6 portion of the topic.
7 Q At that original -- and as I
8 understand, this was a telephone conversation?
9 A Yes, sir.
09:2210 Q At that time were you asked to do
11 anything particularly?
12 A He asked if I would be interested in
13 meeting with some of the attorneys involved in the
14 case. And I said I would be able to do that.
09:2315 Q When was that meeting held?
16 A That was held the latter part of
17 April, to my knowledge. I do not have the
18 specific date.
19 Q Okay. Who attended that particular
09:2320 meeting?
21 A Mr. Clyde Curtis attended that
22 meeting, Dr. Cole attended that meeting, Deborah
23 Lewis, I believe, attended that meeting, or a
24 Carol someone, Brawn, I believe.
09:2325 Q Okay. And can you tell me what

occurred during that meeting?

A At that time, to my recollection, these attorneys stated that they were involved in this case, that what they were doing was getting depositions from various people in the medical profession regarding their opinions on the effect of environmental tobacco smoke in their particular areas. And they were interested in having opinions about environmental tobacco smoke in the pediatric population, including, of course, the Medicaid population.

Q Doctor, with respect to environmental tobacco smoke, do you define that as passing -- passive smoke exposure from the mother and father to the born infant, or do you also include that in the context of maternal smoking while pregnant, or is it a combination of those?

A My area is in pediatrics.

Q Right.

A So my opinion would be that of the postpartum infant and the child and the adolescent.

Q And is that going to be the limitation of your testimony in this case?

A Those are the areas I feel I am

proficient in.

Q Okay. And, Doctor, I will come back to that particular area when we get to talking about your specific opinions in this case.

A Sure.

Q Can you tell me then what was discussed specifically in relationship to your role in the case and any information that you may have requested from the defendants or that they provided you at this meeting?

A We talked about the effect, if any, of environmental tobacco smoke in some of the pediatric illnesses, specifically otitis media, asthma and related respiratory illnesses, and sudden infant death syndrome.

Q Any other areas or topics upon which they discussed?

A Those were the ones that I felt were the ones that I would be able to give an opinion about.

Q At the time of this meeting, did you express any opinions in regards to other areas of pediatric care or neonatal care other than the four you just described?

A To my memory, I think, no -- questions

09:26 1 and my statements were what areas do I think I
2 would be able to render a proficient opinion.
3 Q Okay.
4 A You're talking about maternal smoking,
09:26 5 for instance, or low birth weight or things like
6 that?
7 Q Correct.
8 A That was not in the purview of my
9 opinion.
09:2610 Q Okay. At the conclusion of this
11 meeting, was there some understanding or
12 appreciation that you would be asked to provide
13 testimony in the case?
14 A Yes.
09:2615 Q Okay. And you agreed at that time to
16 do that?
17 A I felt that I would be able to
18 contribute an opinion.
19 Q Okay. Did they at that meeting
09:2620 provide you with any information for your review?
21 A I believe it was at the second meeting
22 early in May when I was provided with these
23 documents.
24 Q Okay. At the conclusion of the April
09:2725 '97 meeting, did you request that they provide

09:27 1 you with any specific information?
2 A I did not.
3 Q All right. Doctor, I assume then that
4 your next meeting with the tobacco folks was in
09:27 5 May of '97?
6 A Yes.
7 Q And who was in attendance at that
8 meeting?
9 A Mr. Clyde Curtis and Dr. Cole. I do
09:2710 not recall -- at one time there was an attorney
11 from Virginia --
12 Q A female attorney?
13 A Yes.
14 Q Okay.
09:2715 A -- whose name I do not recall, but
16 could be provided if necessary.
17 Q And what was the nature of that
18 meeting? What was discussed?
19 A At that time we discussed in more
09:2720 detail my feelings and opinions about the
21 variation of the effect, if any, of environmental
22 tobacco smoke in the areas of respiratory illness
23 or otitis media, asthma, or sudden infant death so
24 that they asked, in generalities, my opinion in
09:2825 these areas based on my clinical experience.

09:28 Q At that time I understand that they provided you with the articles that we have here today, which will be marked as Exhibit 10 to your deposition; is that correct?

09:28 A Yes.

(Deposition Exhibit 10 was marked.)

Q And were those articles provided at your request to having information or did they simply bring them to the meeting for your review?

09:28 A They brought them to the meeting for my information as to what they had been reading.

Q Okay. What was the plan, so to speak, at the conclusion of that meeting?

09:29 A At the conclusion of that meeting, I presume they decided that they would like to proceed with me as giving opinions in these general areas and that I needed to provide them with information, the curriculum vitae and, also, that we would develop a position statement.

MR. BLEVINS: You're looking for the extra exhibits? They're right here.

Q (By Mr. Blevins) Doctor, okay, after your May of '97 meeting, have you since met with the attorneys of the tobacco industry?

09:29 A Yes.
Q Can you tell me, on what occasion was that?
A We had another meeting discussing a draft of this particular thing developing my opinions in each of these areas.
Q When was that --
A And then there was a -- that was the latter part of May. There was also a telephone conversation where a draft was read to me and we were going over the wording and the specifics of the statement.
Q Okay. Since that telephone conference, have you had any additional meetings with the attorneys prior to, I guess, this morning?
A I had a meeting with Attorney Lewis the 11th of May, I believe it was -- no, the 11th of July.
Q And what was the extent of that meeting?
A Extent of that meeting was that there would be a specific time for a deposition.
Q Okay.
A And then yesterday, I met with

09:30 1 Dr. Cole, Mr. Minton, and Mr. Curtis. I had not
2 been involved in a deposition before, and I wanted
3 to get information as to what the structure of a
4 deposition was and what I might be able to
09:31 5 provide.
6 Q During your meeting yesterday, was
7 there any specific discussion of the questions
8 that you might expect to be asked during this
9 deposition today?
09:3110 A No specific questions.
11 Q Did those attorneys share with you any
12 information about the previous depositions that
13 have been taken this week with other doctors and
14 physicians in this area of infant, neonatal,
09:3115 children effects of smoking in the family?
16 A There was one deposition from a
17 pediatric neurologist, if I recall.
18 Q Would that have been Dr. Robert Woody?
19 A I don't recall the name.
20 Q Okay.
21 A And since it's not in my area, it was
22 for information.
23 Q Okay. Did you discuss with him
24 specifics what was asked and answered in that
09:3125 deposition?

09:31 A I don't recall any specifics.
Q Have you been asked to review any depositions whether taken in this case or in the Mississippi or Florida Medicaid cases?
09:32 A No, sir.
Q Dr. Luecke, is it my understanding that this is the first deposition that you've given or just the first one in maybe a while?
A Well, this is the first deposition of
09:32 this type. I've had discussions before --
Q Okay.
A -- in certain cases.
Q Would that have been in the context of, say, an attorney approaching you about
09:32 reviewing a case, say, in a medical malpractice context?
A Yes.
Q All right. In those instances, have you reviewed predominantly for the defense of
09:32 another medical doctor?
A Yes, sir.
Q Okay. Have you ever reviewed or agreed to review a potential medical malpractice case on behalf of a plaintiff's attorney?
09:33 A No, sir.

09:33 Q Okay. And as I understand it then, though, you've never given any testimony in a malpractice case?

A Correct.

09:33 Q Doctor, during the course of, you know, three, four, five meetings over a several-month period, has your opinions with respect to these issues that you've previously identified changed or been modified to any -- to any -- in any way?

A No.

Q So as we sit here today, the opinions that you will express are the same that you expressed to the tobacco companies back in April 09:33 of this year?

A Or that I held last year, all of this year, prior to any contact with them.

Q Okay. Have you been contacted to provide testimony in any of the other state 09:33 Medicaid cases around the country?

A No, sir.

Q Have you been contacted to provide testimony in other tobacco cases, such as the case currently going on in Florida with the airline 09:34 flight attendants, or in an individual's case

against the tobacco company?

A No, sir.

Q Other than the fact that you went to medical school with Dr. Cole, who is now an attorney, do you have any other reason or knowledge or basis to understand why the tobacco industry chose to approach you about testifying in this case?

A I do not know of any other reason.

Q Doctor, during the course of these meetings and what has ultimately culminated in this final report marked as Exhibit 1, who actually prepared that report?

A In our discussions, I laid out in detail my opinions. Those opinions were taken and put in a textural form.

Q By whom?

A By the staff, perhaps Dr. Cole's staff. I was not told who the receptionist was or the secretary who actually put it in textural form.

Then drafts were presented to me for review. And I reviewed it line by line and made the -- any changes that I thought were indicated so that the final statement is sentence by

09:35 1 sentence concurrent with my opinion.
2 Q Doctor, you indicated "drafts." Have
3 you maintained a copy of any previous drafts,
4 alterations or changes to those drafts that you've
09:35 5 made regarding this final report?
6 A I did not get a written draft. These
7 were through a phone conversation that I alluded
8 to earlier.
9 Q During the course of this drafting
09:3610 process, did you make substantial changes to the
11 wording and meaning of the wording or opinions
12 expressed in those reports?
13 A No.
14 Q Okay. In other words, I'm asking for
09:3615 areas outside of, say, grammatic?
16 A Sure.
17 Q And, in your opinion, you did not make
18 any such substantial changes?
19 A Correct.
09:3620 Q Doctor, did you maintain any notes
21 from these various meetings, telephone
22 conferences, etcetera?
23 A I did not.
24 Q Doctor, other than those persons whom
09:3625 you've identified as having attended these

meetings, which as I understand it from your perspective, these are all attorneys; is that correct?

A I understand they are.

Q Okay. To your knowledge, have you had any contact with a direct employee of the tobacco industry?

A Other than someone who called from their office to notify me of a meeting, I have had no contact with anyone else.

Q So you have had no substantial conversations with anyone who, to your knowledge, was a direct employee with the tobacco companies?

A Correct.

Q And that would include doctors or physicians or researchers --

A Uh-huh.

Q -- that played a role in the scientific side of the tobacco industry?

A I have not.

Q Have you discussed your opinions in this case with any other doctors or physicians that you may practice with or who you may find particularly knowledgeable in this area?

A I have not.

09:37 Q Doctor, at any time did the tobacco companies request that you perform any type of document or medical line search?

A No.

09:37 Q On your own, have you performed any medical search for information regarding this topic?

A No.

MR. MINTON: I don't know if I am 09:38 permitted to, but at what time? Do you mean in connection with his work on this case?

Q (By Mr. Blevins) Doctor, my question is specifically in relationship to the work regarding this case.

09:38 A The statement then would be that I have not researched any additional sources regarding this case.

Q Okay. During the course of your practice, have you had the opportunity or reason 09:38 to make a specific search or inquiry into studies and the literature that may be available out in the scientific community regarding environmental tobacco smoke and pediatric illnesses?

A In my reading with journals and 09:38 periodicals over my course of my practice, there

have been many articles regarding environmental tobacco smoke and other areas. So as part of my general knowledge and reading, I have read such articles.

Q Have you in the past prior to your involvement in this case maintained a file that -- in which you would, say, copy these articles that you may have read and put them away under environmental tobacco smoke and pediatric illness or some type of file specific to these issues?

A I know what you mean. No, I have not.

Q Do any of these articles, textbooks, treatises that you may have studied at some point in your practice that you specifically recall today as having formed or helped to form your opinions in regards to the effect of the environmental tobacco smoke on pediatric illnesses?

A I can't recall a specific one, just the general fund of knowledge that's accumulated through the reading.

Q Okay. Doctor, has the attorneys for the tobacco industry requested that you do anything else other than the formulation of this report and the desire to provide testimony? Have

09:40 1 they asked you to do anything else in relationship
2 to this case or the presentation of your opinions
3 in this case?
4 A No, sir.
09:40 5 Q Have you requested anything of them in
6 the way of information or otherwise that, at least
7 at this point in time, has not been completed?
8 A No.
9 Q Doctor, are you being paid for your
09:4010 time here by those attorneys who represent the
11 tobacco industry?
12 A I am being reimbursed for my opinion.
13 And my opinions are those, whether it would be --
14 whatever source, from the so-called defendant's
09:4015 side or the plaintiff's side --
16 Q Okay.
17 A -- or free if it were involved -- my
18 opinion is the same. I am being reimbursed for my
19 opinions.
09:4120 Q I understand. Are you doing this on
21 an hourly basis with them in terms of how you are
22 going to be reimbursed?
23 A I am not certain about that. This is
24 my first position, and I am leaving it in the
09:4125 hands of Dr. Cole.

Q Okay. You and he -- have you and Dr. Cole discussed any specific hourly rates by which you will be compensated?

A We have not specifically.

Q Okay. As you sit here today, do you believe that there is a fair and equitable hourly rate in your mind?

A I am trusting so, but I don't know what it is.

Q Okay. In your opinion, do you believe that that rate should go up for actual deposition or trial testimony time?

A I believe that's the procedure.

Q But, again, a specific dollar amount hasn't been discussed?

A Yes, sir.

Q Okay. I assume then you haven't submitted any bills?

A No bills.

Q Okay. Do you, as we sit here today, have an estimation of how many hours you have spent, whether it's in these conferences or telephone calls or in your review of the information that they've provided, that you have accumulated, so to speak, today in preparation for

this deposition and testimony?

A I don't have a specific time. I was not keeping any hours. And I asked Dr. Cole if he might be able to recall those dates and times. But I have not collated an hourly summary so far.

Q Doctor, outside of the conferences and the telephone calls where you're with the attorneys, so to speak, so you're on your own, say, reviewing information that they've provided or whatever, do you have an estimation of how many hours outside of those meetings and time with the attorneys that you've spent preparing yourself in this case?

A Most of the time outside of these meetings and phone conversations would be spent reviewing these articles that they have been using for their information. And I would estimate that this would be approximately two hours of review of these particular documents.

Q I had asked you about whether you had personally performed a medical search for information. And I believe your answer to that was no in relation to these issues?

A In relation to these issues.

Q The question I have now is, have you

gone back and reviewed case files out of your own practice to further recollect your prior history of treating children with pediatric illnesses that may have a relationship to smoking?

A I haven't reviewed any specific case files.

Q Doctor, in the area of your publications, you had indicated that you had not -- other than the article we've identified, that you have not done any other formal writings. And we covered a number of different topics in which your response was no.

How do you define "formal" versus "informal"? And can you give me some examples of possibly informal participation in writings or publications?

Does that question make any sense?

A Not a whole lot.

Q Okay. Let me try it again.

A But I am a member of the board of counselors, for instance, of the Texas Medical Association. And we formulate and write opinions for the Texas Medical Association, so I'm involved in that type of thing. I have written some articles for various magazines and things like

09:44 1 that in the past on various pediatric topics.
2 Q Okay.
3 A So those -- that type of thing I have
4 participated in.
09:45 5 Q All right. Let me see if I can ask
6 it -- this question this way then. Obviously, my
7 concern is to try to determine whether you have
8 had in the past a particular reason to review the
9 issues of smoking as it related to pediatric
09:4510 problems and in the detail necessary to produce an
11 opinion --
12 A Uh-huh.
13 Q -- or a publication of any form or a
14 policy statement.
09:4515 A Uh-huh.
16 Q Those are the things that I'm
17 interested in.
18 A Sure.
19 Q To your recollection, do you recall
09:4520 ever being in a situation through a committee or
21 an organization or some affiliation that you had
22 in which you were asked to look at the issues of
23 smoking and environmental tobacco smoke in the
24 home and pediatric illnesses?
09:4525 A There have been no specific instances

in my various committee meetings and things where that's been a specific topic.

Q Doctor, in your practice, have you ever had occasion to diagnose a patient with a pediatric illness that, in your opinion, was caused either in whole or in part by environmental tobacco smoke?

A I have had one case I can give of an infant who had persistent rhinorrhea, runny nose, and some respiratory infections, and the father was a cigarette smoker. The child also had allergies, came from a highly allergic family, and was in a day care.

Q Uh-huh.

A And among my recommendations for the child, in addition to medication for the allergy and early treatment of respiratory infections, I recommended that the father not expose the child to environmental tobacco smoke. It was my feeling that possibly the tobacco smoke might have been a precipitating factor or an associated factor, but not the cause of this child's condition.

The child improved with all the various medications. And the father decided to stop smoking anyway, which was a side benefit.

Q Okay.

A I cannot say in that case in my clinical experience that that tobacco smoke caused the child's illness. I can say possibly it was a contributing factor in that infant.

Q And, obviously, Doctor, as a physician attempting to treat illnesses, you have to respond not only to probable causes, but also things that may be a risk factor, such as in this case, maybe smoking was a part of the cause?

A It could have been an associated factor.

Q And as a result, you had to respond to that by making the recommendations that you remove that irritant from the family household?

A Along with the others, uh-huh.

Q Doctor, do you consider yourself an expert in the area of tobacco-related diseases of the newborn or the -- or the infant?

A I don't consider myself an expert at the level of a neonatologist who specifies their practice only in that area.

Q Okay.

A I take care of newborns after they are born. And I take care of the ones that are well

and relatively risk free as far as any other associated factors, low birth weight, for instance or congenital anomalies or things like that. Those are areas where the neonatologist has the knowledge that I refer to.

MR. MINTON: And at the risk of interjecting improperly, but I hope I won't be interpreted that way, it might be helpful to define neonate -- "infant" in terms of gestational age or postpartum age to clear things up.

MR. BLEVINS: That was my next question.

MR. MINTON: Okay.

Q (By Mr. Blevins) Doctor, within the course of your practice, can you tell the jury how you define the various levels of infants from neonates, from children? How do you define those various categories, and what is the predominance of your practice?

A My practice involves every one from newborn through the adolescent period.

Q Okay.

A And the newborn, obviously, this one who is born.

Q Right.

09:49 A Many people talk about infancy is the first 12 to 18 months. Then we talk about the toddler age from about 18 months to maybe three or four. And the preschool age and then the school 09:50 age and then the adolescent age, say, 12 or so. These are arbitrary separations or definitions.

Q Obviously, since part of your practice does involve care of the newborn, I assume that you have at least a passing understanding and 09:5010 interest in the fetal environment because you're going to treat what results --

A Uh-huh.

Q -- to some extent, from that fetal environment?

09:5015 A I'm interested in the fetal environment, but I'm not an expert in that area. That's the area of obstetrics and gynecology.

Q Doctor, based upon that, in your understanding, at least at this juncture of the 09:5120 fetal environment, would you agree that many reviewers, commentators, and others who have written on the subject have said that low birth weight and smoking have a cause-and-effect relationship?

09:5125 A I think such statements have been

made. As far as making that statement out of the context of the other factors in an individual pregnancy, I would not be able to make an opinion as to what effect that one factor in regard to all the other prenatal situations, I would not be able to make a statement about the -- that particular fact out of context of what you're saying.

Q Okay. Would you agree with me -- agree with me that others in the medical field have?

A There are statements that are made that maternal smoking has an effect on the developing infant. But as I say, taking that one statement out of context of all the other factors, I really can't say that that would be enabled as a specific cause as opposed to an associated factor, which is from my general pediatric knowledge, medical knowledge.

Q Okay. I understand. Doctor, you gave us the example of the child that had the runny nose and respiratory infections and your response to that in regards to the father smoking. Can you recall any other instances in your practice where you have been treating a child, infant, and felt that smoking -- environmental tobacco smoke played

09:52 1 a role in the issue which you were treating that
2 you can --
3 A There are other -- children,
4 particularly preschool children, several of
09:53 5 them -- I can't give them by name -- where -- I
6 recall one patient who was taken care of -- a two-
7 or three-year-old who was taken care of by the
8 grandparents. The mother was working. And the
9 grandfather was a tobacco smoker. This child was
09:5310 having some respiratory problems, an allergic
11 child. And my recommendation there, as it is with
12 many people, was that it would be best not to have
13 the child exposed to tobacco smoke.
14 Q Okay.
09:5315 A There was also a dog in the house.
16 There were other factors there, too.
17 Q Okay.
18 A But that was -- that is my
19 recommendation whenever a child is having
09:5420 recurrent respiratory infections when I consider
21 the source of all the possible irritants that
22 might contribute to the child's condition.
23 Q All right. Doctor, Exhibit 2 to your
24 deposition is your curriculum vitae or resume in
09:5425 this case?

09:54 1 A Yes, sir.
2 Q I would like to ask you a couple of
3 questions about that.
4 A Could I have a copy of that? Is it
09:54 5 one of these, I guess?
6 Q Right there.
7 A Is this it?
8 Q That's it.
9 First of all, Doctor, this is dated
09:54 10 1993?
11 A Yes.
12 Q To your knowledge, is there a more
13 current version of your curriculum vitae
14 available?
09:54 15 A There have been no changes in my
16 positions or -- since this was developed.
17 Q All right. For instance, with respect
18 to your memberships and professional associations,
19 all of those would still be true as of today; is
20 that correct?
21 A That would be on Page 1.
22 Q Yes, sir.
23 A Yes. The Dallas Pediatric Society has
24 been changed to the Dallas Metro Pediatric
09:55 25 Society, but the organizations are the same.

Q It says here you are a member -- actually, it says you are a fellow of the American Academy of Pediatrics?

A I am a fellow of the American Academy of Pediatrics.

Q And can you describe to the jury what that means? How does that differentiate from membership or otherwise? I mean, what is the "fellow" standing?

A That's just a statement of the membership. Each person is a fellow of the --

Q Okay.

A -- academy.

Q Have you served on any committees or issue groups involved in the American Academy of Pediatrics?

A I have not.

Q Okay. Do you subscribe or receive, I guess, their monthly or annual publications?

A There is a periodic newspaper that comes from the American Academy of Pediatrics.

Q Is that something that is one of the things that you routinely review to keep you upgraded on medical issues within your field?

A I periodically read that, yes.

Q As I understand it, there are certain subcommittees of the American Academy of Pediatrics that put out special service publications covering specific topics?

A Yes. Infectious disease, school health issues, things of that sort.

Q Okay.

A Yes.

Q And I assume that those would also form a basis of your ongoing education and maintaining your level of knowledge in this area?

A They do.

MR. BLEVINS: Okay. Want to take a break?

THE VIDEOGRAPHER: We're off the video record.

(A recess was taken.)

THE VIDEOGRAPHER: We're on the video record.

Q (By Mr. Blevins) Doctor, I would like you to turn to Page 2 of your curriculum vitae under Current Activities. And the first thing I would like to ask you about is, can you tell me what your relationship is with the Aetna Insurance Company as apparently you are on the quality

management committee?

What does that mean and what are your responsibilities with Aetna?

A With Aetna Insurance Company, it would probably be more specifically called credentialing committee. The managed care companies credential the doctors that they put in their provider manual. And I am one of the members of this credentialing committee where the various doctors that apply are approached. They are credentialed to make sure they are qualified.

Also, we do recredentialing both for Aetna and Harris Methodist and Southwest Physician Association.

Q Is this an area where you only review the credentials of physicians in your area of pediatrics, or do you review credentials in a number of medical areas?

A I'm part of a committee of several specialists, and all of us review those. The reason they have the various specialties, if there's a question about a specific specialty, then there's someone there to address that particular issue. But we review as a committee all of the credentialing applications.

10:05 Q Okay. How long have you been in that position?

A I was in that position for about four years and then not for a while, and then for the last year.

Q Okay.

A So at the time that this was written, this was current, but it is now --

Q Current again?

A -- recurrent. Or whatever you want to call it.

Q Okay. Kind of like fashions, they keep coming back?

A Yeah, don't they.

Q Let me ask you about the last one under Current Activities, the task force welfare section, Goals for Dallas?

A That is still -- more or less inactive at this time.

Q Okay.

A But the Goals for Dallas program is still on paper. That was something that was developed in the '60s by the current mayor at that time, Eric Johnson. And there were various task forces that -- community health was the one that I

was particularly involved in. And that is not -- that's more or less lying fallow at present.

Q Okay. Is this intended to deal with specific problems of those persons involved in the entitlement programs such as Medicaid or Medicare?

A Goals for Dallas was an overview for all the citizens in Dallas.

Q Okay. Does your membership on the welfare section connote any particular relevance to persons who may be receiving entitlements such as Medicare or Medicaid?

A The welfare section did review or was involved in programs that -- entitlement programs, if you'd like to call them.

Q Okay. In your past activities, you served on the drug abuse advisory committee for Dallas Independent School District?

A Yes.

Q In that -- in regards to that committee, was smoking or the use of tobacco products, probably whether as a cigarette or as oral snuff --

A Uh-huh.

Q -- type products, was that considered part of the drug abuse environment?

A The main thrust of that was at that time marijuana and LSD and the psychotropic drugs.

Q Okay.

A That was the main thrust of the charge of this committee.

Q While involved in that committee, did you participate in any policies or procedures or rules drafting that would have dealt directly or indirectly with the use of tobacco products in the Dallas Independent School District?

A At that time I was a member of the Dallas Independent School District school board. And we did consider, among other things, whether or not there should be smoking areas in the high schools or not.

Q I assume that that was for use of teachers and those persons over the age of 18 --

A Well --

Q -- not the actual students?

A No. For the students, there was some question as to whether a smoking area should be provided for the students or not. Then there were discussions at that time in that particular area so that they would have a place where they could

smoke tobacco, cigarettes, rather than behind the shrubs, as you know.

Q Did the Dallas Independent School District decide to enact such a program of creating smoking areas?

A As I recall, there was one high school that had a patio where the tobacco smoking was permitted in certain area. This was left mostly up to individual principals, but there's not a system-wide edict regarding that.

Q Did you have an opinion on whether or not steps should be taken to or to maintain an elimination of tobacco products on a school's premises?

A My opinion would be as a school board member, and I was not in favor of promoting or sanctioning the use of tobacco products during school hours by the students.

Q Doctor, further down, you served on the public health committee, Dallas County Medical Society chairman from 1960-1963. And in that capacity, did you have occasion to deal specifically with groups of people and populations on Medicaid or on Medicare?

A The public health committee was mostly

connected with activities of the city and county health department, so that there weren't any specific programs devised by the committee. When I was chairman of it, our big thrust was oral polio mass immunization programs. And that took up the majority of our time.

So there were none, to my knowledge or recollection, of any specific programs regarding the use of tobacco products.

Q Okay. In your work with the task force on welfare section or the public health committee or other committees, have you, in your opinion, gained any specific or areas of special interest in the Medicaid or Medicare populations of this state?

A I was also on the Community Action Committee at one time and the so-called War on Poverty.

Q Uh-huh.

A So I was very much involved in community issues and community health and had quite an interest in the multiplicity of factors in -- particularly in the Medicaid population that were contributing to health or disease.

Q Out of your participation on the

Dallas Community Action Committee War on Poverty, were there any specific edicts or bulletins or policy statements that came out of that committee dealing with tobacco use, either independently or as part of other risk factors --

A Uh-huh.

Q -- in this Medicaid population group?

A I don't recall any specific documents to that effect.

Q On the next page, it indicates that you were a past vice president and medical director for the commercial Travelers Life Insurance Company?

A At one time there was a small life insurance company, one of the owners was a member of my church. And I would go in a half day a week and review some of their life insurance applications. That was my role or that was my title in that.

Q Okay. Doctor, do you consider yourself an expert in the area of epidemiology?

A No.

Q Do you consider yourself an expert in the area of biostatistics?

A No.

Q Do you consider yourself an expert in the area of toxicology?

A No.

Q Do you consider yourself an expert in the chemical composition of tobacco products, specifically cigarettes?

A The --

Q Chemical composition.

A Chemical composition of tobacco smoke?

Q Yes.

A No, I do not consider myself an expert.

Q Do you consider yourself an expert in the area of pediatric neurology?

A I do not consider myself an expert at the specialist's level of pediatric neurology.

Q Okay. Do you feel that you have some level of expertise or special knowledge in the area of pediatric neurology that would give you a comfort level in testifying about pediatric neurology issues either in conjunction with or in opposition to a pediatric neurologist?

A I would not feel that my testimony in pediatric neurology would be comparable to that of

a pediatric neurologist.

Q Based upon what has been asked of you in this case and the current report that's been generated or any discussions that you've had with the lawyers for the tobacco companies, is it your understanding that you'll be asked to provide any opinions in the area of pediatric neurology?

A I have not been asked to give any specific opinions about -- in the area of pediatric neurology.

Q And I'm assuming that that's an area, if asked, that you would probably say there may be someone else more qualified to talk to you than I?

A True.

Q Given that you have a -- I'm going to refer to it as a working understanding of pediatric neurology issues, are there any particular textbooks, treatises, or articles which you, yourself, have found reliable in the past that you go to or use as a reference or which you have recommended to others to use as a reference that you can recall for us today?

A In the field of pediatric neurology?

Q Yes.

A I do not recall a specific textbook.

Q Nothing in your office that you might flip through in order to find a specific question -- answer to a question that's arisen in your practice that you can recall?

A I have a textbook on genetic disorders and -- and that, of course, includes a lot of neurological conditions, too --

Q Okay. Is the title --

A -- and birth defects. And so that is something that I referred to if there's a particular syndrome or something else. I have, of course, several general pediatric texts which include sections on neurologic diseases in pediatrics.

Q All right. On the specific one regarding the genetic disorders, is that the title of it, Genetic Disorders?

A No, I don't recall the exact title.

Q Can you tell me who the authors are or a author of it?

A It's a compilation, and it's really an encyclopedia of genetic and birth defects listed alphabetically.

Q Okay.

A It's put out by the National

Foundation, as I recall.

Q Doctor, do you consider yourself an expert in the area of fetal medicine or neonatology?

A No.

Q Is that -- would that be a similar type of no to the pediatric neurology area, something that you may have some working knowledge of?

A True.

Q Okay.

A A level of the general pediatrician reads articles and knows about it and attends conferences, but not subspecializing in that field.

Q Okay. Any particular textbooks or treatises or articles which you, yourself, rely upon or review on occasion or recommend to others regarding the area of fetal medicine or neonatology?

A No specific textbooks.

Q Okay. Do you consider yourself an expert in the area of obstetrics and/or gynecology?

A No.

Q Again, any -- I'm assuming there's at least some aspects of obstetrics and gynecology which you have a working familiarity with?

A Yes.

Q Okay. Any textbooks, treatises that you refer to in regards to those issues?

A In the area of OB/GYN?

Q Yes.

A No.

Q Doctor, have you been provided with the opportunity to review the reports of other doctors which have agreed to provide testimony on behalf of the tobacco industry?

A I have received no other depositions or reports.

Q Okay. Have you asked for the opportunity to review either their reports or their subsequent depositions in this case?

A I have not.

Q Are you familiar with Dr. Robert Woody out of El Paso, Texas, who is a pediatric neurologist?

A I am not.

Q What about Dr. Robert Arrington, who is a board certified pediatrician out of Little

Rock, Arkansas, and a member of the University of Arkansas at Little Rock medical staff?

A I do not know him or know of him.

Q What about Dr. Robert Carpenter, who is -- I should remember. I just deposed him yesterday. I believe he is an OB/GYN out of Baylor Medical Center?

A In Houston?

Q In Houston, Texas.

A I do not know him.

Q And then the other expert in this area for the defense is a Dr. Jack McCubbin, who I believe is also an OB/GYN, out of Texarkana?

A I do not know Dr. McCubbin.

Q I take it then that you've certainly had no opportunity to discuss this case with him?

A No, sir.

Q Have you become associated with, had opportunity to discuss with, or know of other defense experts in this case outside the area of the infant issues?

A No.

Q For the State of Texas, Dr. Michael Spear, who is a neonatologist out of Methodist Hospital in Houston, Texas --

A Uh-huh.

Q -- is going to provide testimony. Are you familiar with him?

A I do not know Dr. Spear.

Q Also, for the State of Texas, Dr. Benjamin Sacks, who is with the Harvard Medical School --

A Uh-huh.

Q -- and has both epidemiological and obstetrics and gynecology practice --

A Uh-huh.

Q -- is providing testimony sort of on a national basis for the State of Texas. Are you familiar with him?

A I do not know Dr. Sacks.

Q Doctor, it was -- it's been my understanding and, quite honestly, education through this process that the OB/GYNs and the pediatrics -- American Academy of Pediatrics has on occasion joint committees in order to research particular areas that, say, overlap?

A Uh-huh.

Q And, for instance, they may result in the publication of certain bulletins, such as the ACOG technical bulletins. Are you familiar with

10:20 1 that?
2 A I do not receive that bulletin and
3 have not read it.
4 Q All right. Okay. Doctor, I'm going
10:21 5 to move now into some questions dealing generally
6 with the effects of smoking and certain health
7 conditions that currently preside in the United
8 States and throughout the world.
9 A Uh-huh.
10:2110 Q Before we get into that, I want to ask
11 you about a couple of definitions that you may use
12 and which I'm going to ask you to use in --
13 regarding these questions.
14 A Uh-huh.
10:2115 Q First of all, can you define for me
16 what you consider to be a risk factor for a
17 particular illness?
18 A To me, a risk factor would be some
19 factor, condition, or situation which would be
10:2220 associated more or less with an outcome.
21 Q Doctor, do you draw a distinction
22 between risk factors and something that is
23 considered to be associated with?
24 A I would say "risk factor" is always
10:2225 associated with. So I would more or less consider

those, not maybe synonymous, but equivalent in most cases.

Q With that in mind, can you also define for me how you define "causal," when something is said to have a causal relationship to an outcome?

A A causal relationship, to me, is a specific more or less scientifically determined direct incident resulting in something. For instance, a bullet in the brain would result in death, but it's not the cause of death. The cause of death is the person that pulled the trigger that discharged the bullet.

So you would say technically that the bullet was associated with this person's death, but it was not the cause of death. That's what -- I would think a cause would be a specific, scientifically known, direct factor and a result.

Q Doctor, in your opinion, in order for something to become causal in a scientific context, does it have to be determined with absolute certainty and without other factors or causes associated with it?

A To be called the cause --

Q Right.

A -- every other factor would have to be

eliminated.

Q All right. Would you agree with me that there are many areas of medical and scientific pursuit where the cause is neither determined nor is it in reasonable probability ever going to be determined?

A There are many places where the cause is currently not determined. I will have to leave it to the future as to whether they ever will be.

Q And oftentimes the reason it's not determined is because of the multitude of -- I think you referred to them here today as confounders or other risk factors?

A I didn't use the term "confounders." You could say associated possible factors.

Q Okay. Doctor, do you agree with me that there are instances where there are more than one cause in an event or an outcome?

A Those would be called associated factors, I would think. If it takes more than one factor to have a specific result, then I would say those are associated factors.

Q Can you have a particular person who has an outcome where they have more than one factor involved in their case, but which each

factor independently could have caused it?

A Do you have an example, for instance, of something like that? That's a hypothetical question, and I don't know exactly what -- how you would define that.

Q Okay. Let's say that someone dies and there is both coronary heart disease and a stroke with evidence of emphysema in the lungs.

A Uh-huh.

Q Okay. Now, there are a number of factors or associations -- possible associations with that person's death, correct? And let's assume that they don't die from a car accident.

A Uh-huh.

Q Okay? I mean, my question is, is that there may be a number of medical conditions working simultaneously --

A Uh-huh.

Q -- in someone's particular medical case?

A Uh-huh.

Q And that independently, any one of those events -- I mean, you can die from a stroke, you could die from severe emphysema, you could die from coronary artery disease.

A Uh-huh.

Q If you had both lung cancer and liver cancer existing in a patient at the same time --

A Uh-huh.

Q -- cause of death could be either/or? In other words, now, maybe ultimately one does become the position taken by the autopsy performance --

A Uh-huh.

Q -- but there were multiple conditions working in a case that independently could have resulted in that person's death.

Do you agree that that occurs or can occur generally?

A When there are a multiplicity of potentially fatal conditions in an individual person --

Q Right.

A -- and any one condition alone could result in death, that would certainly be a consistent general statement to make.

Q Okay. The fact that, for instance, someone dies who has both lung cancer and, let's say, bladder cancer, the fact that he may have passed away as a direct result of the lung cancer

10:28 1 certainly doesn't reduce the significance of the
2 fact that that person also suffered from bladder
3 cancer? Would you agree with that?
4 A By "significance," you mean what?
10:28 5 Q That that particular event had a
6 specific health consequence, may not have resulted
7 in the death --
8 A Uh-huh.
9 Q -- but it may have substantially
10:28 10 complicated the person's treatment over time.
11 A Uh-huh.
12 Q It may have caused them a significant
13 amount of pain. It may have contributed to other
14 health problems.
10:28 15 A Uh-huh.
16 Q But all those things didn't add up to
17 the death, the lung cancer did?
18 A Uh-huh.
19 Q But in your mind, does that decrease
10:28 20 the significance of the fact that the person also
21 suffered from bladder cancer?
22 A The bladder cancer, per se, was a
23 specific condition which, as you say, could have
24 resulted in pain and morbidity. And taking the
10:29 25 bladder cancer as bladder cancer, it was

significant in itself.

Q Okay. Even though it did not result in the ultimate harm, so to speak?

A Yeah. It was a significant thing in itself.

Q Okay. All right. Doctor, let me then ask you about these issues, which I'm going to ask you about the relationship between smoking, generally --

A Uh-huh.

Q -- and certain medical conditions. And in your opinion, I would ask that you provide me with whether you believe that those conditions are a risk factor, slash --

A Uh-huh.

Q -- association with smoking --

A Uh-huh.

Q -- or whether the level of scientific knowledge based upon your understanding is such --

A Uh-huh.

Q -- that they are causal --

A Uh-huh.

Q -- related or that you don't believe there's a causal -- a relationship at all between the two factors, or that you have no opinion.

A Uh-huh.
Q Okay?
A All right.
Q Do you understand my categorization of those?
A Sure, I understand it.
Q All right. Doctor, what is your opinion about the relationship between smoking and lung cancer?
A My opinion as a doctor, but not as an expert or an epidemiologist or an oncologist or anyone else who specifically studies these problems, is that the preponderance of articles shows that there is an increased incidence of lung cancer in people who are long-term cigarette smokers.
Q Do you believe that that balance of literature supports the conclusion today that it's -- that smoking is a cause of lung cancer?
A I think all of the articles indicate that it's an associated factor.
Q Okay. So your belief -- and then -- go ahead?
A I'm sorry. Go ahead.
Q So your belief with respect to smoking

and lung cancer would be it's a risk factor or association?

A It apparently is an associated factor --

Q Okay.

A -- in many cases of lung cancer.

Q All right. What about smoking and esophageal cancer?

A I am not a gastroenterologist, and I know that a lot of esophageal cancers are due to reflux and other conditions such as that. So I am not really conversant about the incidence of esophageal cancer and any other associated factors.

Q Okay. So that would be a -- kind of a no opinion?

A I would say I have no opinion to contribute in that condition.

Q All right. Smoking and pancreatic cancer?

A I do not know of any association in my knowledge about an association there.

Q Okay. Urinary bladder cancer?

A I recall some time ago an opinion that heavy tobacco smokers may have an increased

incidence of bladder cancer. I also remember cyclamate and saccharine were supposed to be implicated in bladder cancer, too.

So I could not say, other than some article in the distant past, that there could possibly be that as an associated factor. But that would be almost no opinion to just a vague recollection of something in the past.

Q What about smoking and laryngeal cancer?

A Articles that I recall are that there is an increased incidence of laryngeal cancer in association with tobacco smoke.

Q Oral cavity cancer?

A Tobacco smoking?

Q Yes.

A Not the other use of tobacco products, such as --

Q Talking about specifically tobacco smoking in this instance.

A Which types of oral cancer?

Q I'm not sure that I can answer that.

A There are different types, leukoplakia and sarcomas and --

Q Are you aware of any association

between smoking and any form of oral cancer?

A I wouldn't be able to make a statement about any form of oral cancer in tobacco smoking.

Q Okay.

A Cigarette tobacco smoking, not pipe smoking.

Q All right. What about smoking and coronary heart disease?

A I'm not a cardiologist, so I can't say about the specific association. General medical knowledge suggests that nicotine is a vasoconstrictor. And in people with impaired coronary artery circulation, that additional vasoconstriction may impair coronary circulation. General knowledge, but not able to give you an expert opinion in that.

Q What about smoking and the incidence of stroke or strokes?

A I do not know of anything that I can recall in that area.

Q What about smoking and chronic obstructive pulmonary disease?

A I'm not a pulmonologist, so, again, this is general knowledge, that tobacco smoke is an irritant. And in people with impaired

pulmonary function or recurrent infections or allergies, that tobacco smoke would be a condition -- considered an irritant that could be considered a contributing factor in that illness.

Q What about smoking and respiratory infections such as pneumonia or influenza?

A Those are infectious diseases, so that tobacco smoke would not determine whether a germ came down and gave you pneumonia.

Q And based upon your general understanding, is smoking a risk factor for predisposing the lungs to such infections or diseases?

A In a general knowledge, not expert, anything that may cause an irritation to the respiratory tract, and tobacco smoke to be considered one of the many irritants around that may make people more susceptible to infection.

Q What about smoking and peripheral artery occlusive disease?

A The nicotine -- general, again, not an expert in cardio and vascular diseases. If nicotine is a vasoconstrictor and peripheral vascular disease is exacerbated by further construction on the peripheral vessels, then we

might say that there could be an association there, an association --

Q Okay.

A -- in a person who's already predisposed to that condition anyway.

Q What about smoking and gastric or duodenal ulcers?

A Again, general, I'm not a gastroenterologist. That whole field of gastric and duodenal ulcers is wide open from my general -- having to do with hyperacidity and the various changes in medication. So I can't say at all what degree, if any, there would be an association with tobacco smoking aside from the other factors involved.

Q Doctor -- I'm sorry.

A H polyuria infection, for instance, and things that you probably know about.

Q Doctor, in your opinion, is tobacco and its various chemical properties or a component part of tobacco an addictive property?

A I can't make a statement about addiction with tobacco or its ingredients. I know personally many people who find it extremely difficult to discontinue their use of tobacco

10:37 1 products. The surgeon general's report, as I
2 recall, sometime back, saying that it may be
3 addictive.
4 Eating in some people is addictive.
10:38 5 So there -- as we all know, there are people who
6 use tobacco who are on -- do not stop using
7 tobacco.
8 Q Okay.
9 A What's your definition of "addictive,"
10:38 10 would you say?
11 Q Funny you should ask, Doctor.
12 A Yeah, I would like to know. Because
13 there are several definitions having to do with
14 psychological and physiological effects of nonuse
10:38 15 of a product.
16 Q Doctor, you're obviously familiar with
17 the American Heart Association?
18 A Am I familiar with them?
19 Q Yes, sir.
10:38 20 A I know there is such an organization.
21 Q Have you participated in any way with
22 American Heart Association committees or in any
23 way their medical review of literature or general
24 attempts to improve the public health in the
10:39 25 United States?

10:39 A No.

Q Do you have any reason to believe that they are not a worthwhile organization that is attempting to improve the general health of the United States' population?

10:39 A You're talking about the entire organization?

Q I'm talking -- yeah, in terms of an organization as a whole.

10:39 A I believe that's their purpose is to try to improve in regard to cardiovascular diseases.

(Deposition Exhibit 7 was marked.)

10:39 Q Okay. Doctor, let me hand you what's been marked as Exhibit 7 to your deposition, which is an article out of the American Heart Association, medical and scientific statement and special report on the active and passive tobacco exposure, a serious pediatric health problem.

And specifically, on the first page, first paragraph, I want to ask if you agree with this statement generally. "Cigarette smoking and passive exposure to tobacco smoke are important causes of mortality in the United States. Active

and passive exposure to tobacco smoke are projected to contribute to more than 400,000 deaths annually."

Generally speaking, do you agree with that statement?

A I'm not a statistician. I -- and I do not have the reference. These apparently reference -- do you have the references --

Q Yes.

A -- one and two?

Q Yes, sir, in the back are all the references to this particular article.

A By title, but not the text?

Q No, not the actual articles themselves, no, I do not --

A Well, that's what I would wonder, how they got 40,000 rather than 41,000 or --

Q Four hundred thousand.

A -- or 400,000 or so. So I could not accept that word for word.

Q Okay. Let me then read for you, specifically to your question about addiction, on the second column of that first page, the first paragraph -- first full paragraph beginning with "primary." Do you see where I'm at?

A Second paragraph, yes.

Q "Primary prevention of smoking is essential because nicotine is one of the most highly addictive substances available. Nicotine meets all the criteria that define an addictive substance. It produces brief, pleasurable psychoactive effects. Its use occurs despite the known harmful specifics. Tolerance to both the pleasurable and unpleasant effects develops during early uses. Higher doses overcome tolerance. And withdrawal symptoms occur when the substance is no longer used."

Doctor, that would be my definition of "addiction." Do you agree or disagree with that?

A That looks like one good definition of "addiction."

Q Okay. Based upon that and your knowledge, either personally or professionally, would you agree with me that tobacco smoke, tobacco products are addictive?

A May be addictive.

Q Okay. Doctor, we will come back to this article in a little greater detail on some other issues.

A That's good, uh-huh.

Q But I would like to continue on then with several questions. Again, I'm going to ask whether you agree or disagree with these statements.

A Uh-huh.

Q And this is based both upon your personal and professional background. First of all, would you agree that cigarette smoking is the single most important preventable environmental factor contributing to the illness, disability, and death in the United States?

A The single most?

Q Yes, sir.

A In other words, there are more people that get sick or die from the use of tobacco products than anything else?

Q As I would probably say contributing to the sick, to the illness, disability, and death, correct.

A I would say that it's one of the major ones. I don't have any statistics on alcohol, the use of alcohol --

Q Okay.

A -- or the use of -- or the life-style habits of other people, like overweight and things

like that.

So I think I would certainly concur that it's a major factor in morbidity and mortality. But I wouldn't be able to say it's the single -- because I don't know the statistics for these other life-style conditions.

Q All right. Would you agree with me that the elimination of smoking would yield substantial benefits for public health?

A For public health?

Q Yes.

A You mean for the individuals if they did not smoke --

Q Yes.

A -- instead of if they did smoke.

Q Yes.

A I think there's no question, from my general and personal opinion, that the population would be better served if they were not using tobacco products, people were not using tobacco products.

Q Do you, yourself, smoke?

A No, I do not at present. I did smoke for some years when I was in the Navy.

Q Okay. Have you yourself or any member

of your family been diagnosed with a tobacco-related illness?

A No.

Q Are you married?

A Yes.

Q Do you have children?

A Yes.

Q And you actually have grandchildren?

A Uh-huh.

Q I know that because there's a Luecke, IV?

A That's correct.

Q All right. During your wife's pregnancy, did she smoke?

A During one of the four pregnancies, I think that she did smoke.

Q Okay. Were there any pregnancy -- or adverse pregnancy outcomes to your recollection associated with that pregnancy?

A No. That was one of the heavier newborns.

Q Okay. Did any member of your family smoke, any of your children?

A My wife continued to smoke for some years. To my knowledge, none of my children

have smoked. I think maybe one of my daughters smoked some in high school or college, but not currently.

Q Okay. Do you have -- with either your daughters or if your sons are married, what would you tell them about smoking during pregnancy?

A Well, I would tell them that I would not care for them to smoke at all.

Q Okay.

A And that there are some data -- although I am not a statistician -- that suggests that heavy smoking by the mother during pregnancy may have some adverse effects on the developing fetus.

Q Okay. Specifically --

A I would defer to her OB/GYN man for that opinion.

Q Doctor, let me then turn our focus on maternal smoking or passive smoking and the effects on fetuses and infants --

A Uh-huh.

Q -- and then up through, I guess, toddlers, first of all, using the same definitions of risk factor, slash, association versus causal versus no opinion versus no association whatsoever

in your opinion, using those four categories, do you believe -- or what do you believe is the relationship between maternal smoking and low birth weight or small for gestational age infants or newborns?

A I am not a neonatologist or a perinatologist --

Q Sure.

A -- so I do not have any statistical data. I know that maternal smoking is cited as an associated factor which may correlate with low birth weight.

Q Okay. You've seen that in literature that there is an association between maternal smoking and low birth weight or small for gestational age newborns?

A I have seen articles and also heard that it can be an associated -- or it's considered an associated factor.

Q Okay.

A I can't recall an article where that is cited as a specific cause separate from anything else --

Q All right.

A -- in the prenatal period.

Q What about maternal smoking and the incidence of abruptio placenta?

A There's -- again, I'm not an OB/GYN, but I understand that there may be an increased incidence in that. There's also other factors that are causing an increase in abruptio placenta, too, which you may know is coming out in the current literature, aside from tobacco smoking.

Q Okay. What about maternal smoking and the incidence of placenta previa?

A I have no opinion about that since I have no information.

Q What about maternal smoking and spontaneous abortion?

A No opinion.

Q What about maternal smoking and congenital limb reduction?

A No opinion as far as having any knowledge of that.

Q What about maternal smoking and the incidence of ectopic pregnancies?

A I have no knowledge, so no opinion about that.

Q What about maternal smoking and preterm delivery, "preterm" being prior to the

conclusion of the 37th week of gestation?

A I cannot recall any statistics that would relate to that specifically. I think, again, the low birth weight child would be frequently, by definition, a preterm delivery, many of them.

Q Okay.

A So that there would be, again, the possibility of an associated factor.

Q And let me make sure that -- because I have certainly seen studies where "preterm" was defined in the area of low birth -- there was some mixed definitions between low birth weights versus preterms.

A Yes.

Q So I want to be sure that you and I are talking about the same thing.

A Uh-huh.

Q When I talk about low birth weight babies, I'm really referring to small for gestational age babies or those babies that are full-term but under 2500 grams.

A Uh-huh.

Q Okay. So I'm talking about actual reduction in birth weight --

A Size.
Q -- for any given gestational age --
A Uh-huh.
Q -- which may or may not be reflective of smaller growth. I mean, the actual smaller circumference of the head, the smaller body frame --
A Uh-huh, uh-huh.
Q -- it could be related to that, but it doesn't have to be.
A Uh-huh.
Q But I am talking about smaller birth weights at every level of gestational age.
A Uh-huh.
Q Versus when I say "preterm," I am talking solely about the issue of being born prior to the conclusion of the 37th week.
A Uh-huh.
Q Okay. So just so you and I understand it when I use the term, that's how I'm using it. All right?
A Yes.
Q So I think what we've talked about is --
A Sure.

Q -- you understand from the literature that there is an association between maternal smoking and low birth weight or small for gestational age; is that correct?

A In the literature, I believe there have been articles regarding that as an associated factor, yes, sir.

Q Okay. Pre -- as to maternal smoking and preterm delivery, you, as I recall, do not know of any specific statistics, can't draw any on that particular issue?

A Talking about the premature delivery?

Q Yes, the birth of child prior to the completion of 37 weeks.

A I do not have specific data that I could render an opinion about that.

Q Okay. Generally, does -- is there a relationship between maternal smoking and the existence of infant mortality?

A By "infant mortality," do you mean prenatally or postnatally.

Q Postnatally.

A And by "infant," you mean how long after --

Q Up through 18 months.

10:51 A -- birth? Up to 18 months?
Q Yes.
A No, I don't know of anything. You're talking about maternal smoking and postnatal mortality.
10:51 Q Correct. For instance, I think that it would be fair to say that if, for instance, such things as preterm deliveries, low birth weights, small for gestational age babies --
10:52 A Uh-huh.
Q -- that then they would have a corresponding relationship with infant mortality?
A Uh-huh.
Q I think there's a clear issue there.
10:52 So the question is, is through those events, does maternal smoking have an impact on infant mortality?
A Other things being equal, a small child surviving a neonatal period without any
10:52 significant anomalies or abnormalities would have just as good a prognosis as far as mortality -- or mortality or morbidity as a term infant.
Q Okay. Doctor, in your opinion then, a full-term but small, low birth weight baby, under
10:52 2500 grams, in your opinion has the same -- I

don't want to use -- life expectancy?

A Or prognosis for --

Q Same prognosis as a baby in excess of 2500 grams? Is that -- in my understanding, is that your opinion?

A I'm trying to just -- in my memory, they're small for gestational age babies --

Q Right.

A -- who otherwise have mature lungs and who otherwise have no associated health conditions who thrive postnatally as well as a heavier baby who was delivered later.

Q Okay. But in your opinion, the issue of low birth weight independently is not associated with a higher incidence of infant mortality?

A The birth weight, if you're talking about as such, without any other associated factors, is not a prognostic thing about their mortality in the first 18 months --

Q Okay.

A -- in my experience.

Q Okay. Doctor, what about the -- any relationship between maternal smoking and mental retardation of the infant?

10:54 A I'm not a developmental pediatrician, so I do not have any data about the association there.

Q Okay. What about maternal smoking and the incidence of neurological disorders, which would include behavioral disorders, hyperkinesis --

A Hyperkinesis.

Q However you say that, I have tried it several ways, that and ethnicity or whatever are just two words I cannot get hooked on in this deal.

A I have trouble with them, too.

Q Any relationship, to your understanding, between maternal smoking and neurological disorders of that nature?

A I cannot recall any specific data about that, not being a neurologist.

Q Okay. And maternal smoking and cognizant -- cognitive deficits, which would be not mental retardation, but rather lower IQ function --

A Uh-huh.

Q -- comprehensive ability, that area?

10:5625 A Uh-huh. I have no opinion about that

or no data.

Q Okay. What about maternal smoking and fetal hypoxia?

A That would be OB/GYN and perinatologist.

Q Okay. So no opinion there?

A I don't have any data to make an opinion about that.

Q Okay. Maternal smoking -- and I have seen it referred to in the literature as infertility, but I don't think that's really what it is in common parlance.

A Uh-huh.

Q What I think it is, is the decreased ability to conceive or an increased time for what you would normally consider the period of time to conceive.

A Uh-huh.

Q Have you -- have you seen or read any relationship between maternal smoking or smoking by the woman --

A Uh-huh.

Q -- in that instance and a decreased ability to conceive or an increase in the time in which that woman does conceive?

A I have no data in that field --
Q All right.
A -- so I would have no information to base an opinion in that OB/GYN area.
Q Okay. Doctor, we're going to go towards some more specific areas that I think you actually thought you would testify about today.
A Okay.
Q And before we do that, we need to change videotape.
A Okay.
THE VIDEOGRAPHER: We're off the video record.
(A recess was taken.)
THE VIDEOGRAPHER: We're on the video record.
Q (By Mr. Blevins) Doctor, continuing then -- and we're going to cover these opinions, I believe, in greater detail when we talk about your report.
A Uh-huh.
Q But just for the record, do you believe that there exists a relationship of any kind between maternal smoking and the incidence of sudden infant death syndrome?

A Some of the earlier reports on sudden infant death syndrome do mention maternal smoking and, also, postnatal smoking in the family, environmental tobacco smoke as an associated factor in some cases of sudden infant death syndrome.

Q Okay. Your personal opinion with respect to a relationship between either maternal smoking or environmental tobacco smoke and sudden infant death syndrome?

A I can't say. I'm not a statistician or a perinatologist. And I know that the whole issue of sudden infant death is still an undefined area. They used to talk about tobacco exposure, pre and postnatally, soft beds, things like that. And as you know now, the major factor that they've found is sleep position.

So that the percentage or degree of association with tobacco products and sudden infant death, I can't make a statistical or an expert opinion about the degree of association. I know that in the literature it's still considered one possible associated factor.

Q Doctor, you're familiar with the surgeon general's report, correct?

A I have not read the whole surgeon general's report. Which one? Of 1950 or 1966 or which one?

Q First of all, generally speaking, you're aware of the surgeon general and the issuance of their biannual or yearly reports on various topics concerning public health in America?

A I know as a public health person the surgeon general issues reports, uh-huh.

Q And I'm sure that you're aware that at least since 1964, the surgeon general has routinely issued reports on the effect of tobacco smoking in the public health system?

A Long before that. I think 1950 was when Luther Terry, the surgeon general, started issuing reports in that area, public health reports.

Q I assume that you understand that the surgeon general's report is both a compilation and review of studies in various health areas as well as individual specific studies and projects that are done under government auspices through, for instance, the Center for Disease Control?

I mean, it's a combination of both

things. It's both reviews and publications out there generally, and then at the same time, it also includes information from governmental agencies in a more direct fashion, such as its association with the Center for Disease Control?

A That's what you're telling me compiles the surgeon general's report?

Q I am asking you, first, if you were aware that that's what compiled the surgeon general's report.

A I don't know everything that goes into it, but that certainly sounds logical from a public health point of view.

Q Okay. Are you familiar with the surgeon general's process and peer review process that goes into the articles and conclusions and summations of the surgeon general's report?

A I am not familiar with the specific steps in the peer review and reviews.

Q Okay. Can you agree with me that the surgeon general's report is one of the most peer reviewed documents in the medical community?

A In the public health community?

Q Yes.

A Since it is a public health document,

it obviously or logically would be a summation of public health opinions in the various subjects it addresses.

Q Are you aware of the surgeon general's conclusions in regards to the role of maternal smoking and the development or incidence of sudden infant death syndrome?

A I haven't read a specific textural thing. Do you have that available?

Q Doctor, first let me hand you what's been marked -- or not marked. But this is a clean copy of the surgeon general's report from -- by "clean," I mean, it doesn't have my markings and highlighting on it --

A Uh-huh.

Q -- of the surgeon general's report of 1979 Part I of II. This includes the acknowledgments, it includes the table of contents, and, specifically, it includes Chapter 8, which is entitled Pregnancy and Infant Health, which is the only area that I'm particularly interested in. And that's why it's reduced down, so that I don't have to carry two complete copies of the surgeon general's report around with me everywhere.

A I see, uh-huh.

Q Specifically, I can refer you in that document to Page 8 -- Chapter 8, Page 44.

A Page 44?

Q Yes, sir.

A I have Page 44.

Q Yeah.

A Chapter 8, headed with Table 12?

Q No, Table 13, I believe.

A 13.

Q Right. And underneath that, it begins with -- or there is a category for sudden infant death syndrome --

A Yes.

Q -- which begins, Maternal smoking habits have been ascertained in several studies of the sudden infant death syndrome. In all of these, a positive -- I will repeat. In all of these -- referring to the several studies -- a positive association has been found between maternal smoking during pregnancy and the incidence of sudden infant death.

A Uh-huh.

Q It goes on and discusses various studies that were included. It has tables

regarding sudden infant death issues. And on Page 845 it -- about, oh, three-fourths of the way down, it indicates under these authors, starting on the right-hand side, "these authors"?

A All right, yes.

Q Indicate that exposure to cigarette smoke, passive smoking, appears to enhance the risk for SIDS for reasons not yet known. However, whether prenatal or postnatal exposure is more important cannot be determined.

Does that seem to indicate to you that there appears to be both a component of maternal and post-birth smoking related in these studies showing an increased incidence of sudden infant death syndrome?

A The fact that it cannot be determined means to me that they can't say whether it's a factor or not a factor.

Q Well, I think, if I am correct, Doctor, the sentence says, however, whether prenatal or postnatal exposure is more important --

A Uh-huh.

Q -- aren't they really talking about the relative application of one or the other as

opposed to whether or not there's an effect overall?

A Or any effect.

Q I think clearly from the first sentence that we read, "In all of these, a positive association has been found between maternal smoking during pregnancy and the incidence of sudden infant death syndrome," seems to answer that question of a review of the articles in 1979?

A And this was in 1979 --

Q Correct.

A -- which was 28 years ago or 18 years ago.

Q Right. So as of -- and it is your position then that the state of knowledge with respect to sudden infant death syndrome has changed making maternal smoking or environmental tobacco smoke a less important factor?

A Dramatically, yes.

Q When, in your opinion, did those changes begin to take place?

A I would say the most dramatic change in considering associated factors had to do with sleep position of the infant, that in New Zealand

there was a study and in Australia, and then statements and now generally accepted feeling that the infant sleeping in a prone position is more at risk for sudden infant death than the infant sleeping on its back or side.

So I think the whole issue of sudden infant death, the etiology or associated causes, has been dramatically changed since that one finding.

Q Okay. Let me ask you this question, Doctor. When time frame wise, do you believe that that occurred?

A The change in --

Q Obviously, you've said from '79 to now, there's been this dramatic change, okay?

A In the incidence or in etiology of sudden infant death.

Q My question is, in your opinion, when did that change occur? Did it occur in 1980, '85, '88, '90, '91? I'm trying to figure out in your mind where that dramatic change occurred in the thinking?

A I was trying to remember when the first article appeared on the sleep position and the incidence of sudden infant death. I would say

it was in the early '90s.

Q Okay.

A And it has evolved over the last four years specifically.

Q Okay. So, for instance, if the 1990 surgeon general's report agreed and restated the same position from the 1979, would your opinion also be that the 1990 has now been outdated? Would that be your opinion?

A I would have to look at the references and --

Q Well, Doctor, I found a summary reference. I just can't find one that cites specific studies. That's what I was looking for.

A Oh, okay. It's difficult to take one statement out of context with the entire thing. I was just scanning the summary on the other page when it talked about the variability between risk ratios and discussed socioeconomic status, age, parity, and others, and others.

So what they allude to is risk factors. This perhaps doesn't follow what your line is. But on Page 46 and 47 of this report, it also lists many other things that were considered variables.

And as I say, I think it was in Corinthians, we see through a glass darkly. We would all like to see face to face and have 100 percent, yes, this is exactly it. But in this 1979 and '80, I remember we were seeing through a glass very darkly with regard to SIDS. And maternal smoking was certainly implicated.

I remember a TV thing where it showed parents that had a child who had died of SIDS and he was smoking a cigarette while he was talking. And so, you know, you have a -- in your mind, an association. But when we get down to scientific factors and causality, I -- as you know, there's been a lot of variation in this whole area in the last 18 -- 15 to 18 years.

Q Okay. Doctor, are you familiar with Dr. Richard L. Naogh, university -- professor of pathology, chairman department of pathology with The Milton Hershey Medical Center in Pennsylvania?

A I do not know Dr. Naogh.

Q Are you familiar with his book?

A Not offhand.

Q Disorders of the Placenta, Fetus, and Neonate, Diagnosis and Clinical Significance.

A No, sir. That's an area of obstetrics

and gynecology.

Q Okay. Would it you surprise you if Dr. Naogh in his book, which was published after 1990, only because I can find certain references that at least go to 1990 --

A Uh-huh.

Q -- okay -- has determined that after taking other identifiable risk factors into account, maternal cigarette smoking during pregnancy accounted for 16 percent of the SIDS deaths in the CPS, which is, as I understand it, the collaborative perinatal study that was done including some 56,000 pregnancies --

A Uh-huh.

Q -- between 1959 and 1966.

A Uh-huh.

Q And then numerous researchers have taken that information since then and done all types of comparative study analysis to try and determine the cause and effectual relationships in various perinatal problems.

A Uh-huh.

Q So does it surprise you that as late as 1990, 1991, that Professor Naogh would have come to the conclusion based upon a very detailed,

hugely populated study --

A Uh-huh.

Q -- that after taking other identified risk factors into account, maternal cigarette smoking during pregnancy accounted for 16 percent of the sudden infant death syndrome deaths?

A Uh-huh.

Q Does that surprise you?

A No, that would not surprise me as the statement he made as a statistician. I don't know, as you say, without looking at the references where he gets 16 percent instead of 14 or 20 or 10.

But it was after 1990 when the predominant role of fetal position or infant sleeping position was evolving.

Q Okay.

A So I would not know, going back to Dr. Naogh, again, now, in the review of everything that's happened in the last seven years, just exactly from a statistical point of view, if that statement would be something he would agree to at this time.

Q Let me ask you, in your opinion -- and I think I understand that you feel that there has

been a significant change in the etiology of sudden infant death syndrome that you believe may have updated some of the opinions that I've talked about today.

In your mind, does that eliminate maternal smoking as having played any role in sudden infant death syndrome cases?

A That doesn't eliminate in my mind that it could be among the associated factors.

Q Okay.

A It eliminates in my mind the predominance in the basis of new information and some of the causalogy of the sudden infant death.

Q So it reduces its significance; would that be a fair statement?

A I think it reduces the significance in the possible reasons for sudden infant death.

Q Okay. But it's still something that would be qualified as a risk factor or association with sudden infant death syndrome?

A You would list maternal smoking. You would list allergic reactions. You would list certain food problems. You would list gastroesophageal reflux with aspiration. You would list prematurity. You would list, you know,

child abuse. A lot of dead babies that come in may not have died by themselves. And I'm sure you're aware of that.

Q Okay. Doctor, going back --

A So if you're listing --

Q I'm sorry.

A -- you know, a differential, all the possible factors, you would have to put maternal smoking in there, I would, yes.

Q That's all I was trying to get to.

A Okay.

Q Let me, again, go onto a new area.

A Uh-huh.

Q What about a relationship between maternal smoking or environmental tobacco smoke in the home and the development of upper respiratory infections in infants?

A This is an area where I have had vast clinical experience. And there are many articles, again, by people who have varying opinions about that. My opinion from my clinical experience is that, other factors being the same, the possibility of allergy, of siblings in the home with frequent respiratory infections, and things like that, that in some infants and preschool

children, say, infants to maybe four or so, that tobacco smoke could be considered one of the irritants that might predispose them to some increase. But I work on a one-to-one basis. So I couldn't say statistically that there would be an instance. And in any one case, I couldn't say that that was a factor. I alluded to one as I said earlier in the testimony.

Q So in the context --

A In the context --

Q I'm sorry.

A -- of my clinical experience, I consider the possible role of secondhand smoke or environmental tobacco smoke --

Q All right.

A -- in children who have respiratory infection, particularly in the preschool age. But then I have many children -- there was one just last week, an older child, and an example of a mother who has tried everything to stop smoking, the patches and the chewing gum and cessation programs and everything else. It has been a perfectly healthy child.

Q Right.

A I was one of six children. We lived

in a two-bedroom house. My father was a chain-smoker at the time. None of us developed any allergic symptoms or had any -- so I -- I'm on the frontlines as a practicing person.

Q Uh-huh.

A I don't sit around and look at statistics and things like that. In my experience, I will have to say that there probably could well be an associated factor in small infants in some cases with environmental tobacco smoke. But in the older children, I cannot see on a one-to-one basis a consistent effect.

Q Doctor, let me ask you, because you broached an area a little bit off the track from where we were headed, which is, in your mind, going back to your definition of causal, if we assumed that something had a causal relationship with an outcome --

A Uh-huh.

Q -- does that mean that that event always causes that outcome? Do you understand my -- the point I'm making?

A Not exactly. If --

Q For instance, if we assumed -- and you haven't agreed to this. But let's assume for the

moment that smoking has a causal relationship with lung cancer.

A Uh-huh.

Q All right? Would you say then that smoking always has to cause lung cancer even if it's -- if it's causal?

A Well, there are two statements you made. Assuming that smoking causes lung cancer, so I can't ascribe to that --

Q Uh-huh.

A -- in my definition of causal.

Q I understand. I knew that.

A Uh-huh.

Q But my question is, simply because something is causal --

A Uh-huh.

Q -- does that always mean -- always means that the event results in the outcome?

A If there were no outcome, then it wouldn't be a cause.

Q Okay. So if I take a hundred people and they all smoked --

A Uh-huh.

Q -- and 99 of them have lung cancer --

A Uh-huh.

Q -- but the other one person doesn't have lunch cancer --

A Uh-huh.

Q -- does that mean then that, assuming all the other variables are controlled, that smoking doesn't cause lung cancer because it didn't cause it in just one person?

A Well, obviously it doesn't always cause lung cancer. There are people that get lung cancer that don't smoke.

Q Right.

A And there are people that smoke that don't get lung cancer.

Q Right.

A So I can go on to say that it seems to be an associated factor --

Q Uh-huh.

A -- in people in that particular condition. But I'm not a pulmonologist.

Q Sure.

A This is general pediatric knowledge. But I don't think you can put a label of cause on there as opposed to associated factor or risk factor, if you want to call it that.

Q All right. I'm going to try it this

way.

A Okay.

Q Is there something in your area of specialty that you feel has a cause-and-effect relationship --

A Yes, uh-huh.

Q -- any area? Give me an example.

A Strep throat, you have tonsillitis, you do a culture, there's a Group A beta hemolytic streptococcus there. I would cause that a -- I would call that a cause of this person's tonsillitis.

Q Okay. So strep throat in your mind is a cause -- is the cause of tonsillitis?

A The germ in the tonsil in that case is the reason they have tonsillitis. If the alpha beta hemolytic streptococcus was not in there --

Q Uh-huh.

A -- and was not causing clinical symptoms --

Q Okay.

A -- then that wouldn't hit -- the child wouldn't have tonsillitis.

Q All right. I guess my next question -- and, again, this is outside the area I

know anything about, because I know only a little bit about this area we're talking about, so this is outside of my area. Can you have a situation where someone gets strep throat but they don't get tonsillitis?

A Strep throat is a clinical diagnosis, which means it's a disease entity.

Q Uh-huh.

A There are people who carry -- who can carry the streptococcus germ without clinical illness.

Q Uh-huh. But does the fact -- see, I don't know that I see a difference between strep throat and tonsillitis, so I may be completely off base here.

A You have posterior pharyngeal lymphoid hyperplasia --

Q Uh-huh.

A -- and not specific terms. You can have sinusitis or adenoiditis. There are other areas in the oral cavity other than the tonsils that can be involved in a specific organism. So -- but when you use the term "strep throat," you generally mean in lay parlance that it's an infection of the tonsils --

Q Uh-huh.

A -- caused by the streptococcus. But people who have had their tonsils removed can still have streptococcal infection of the throat.

So strep throat in lay parlance or general understanding would be an infection in the oral cavity or in the throat by a streptococcus germ.

Q Well, I'm trying to think of an example that will help me get to my point, but I don't think I can --

A If you just give me your point --

Q And I guess, my point may be wrong. So that's what I'm trying to get to is --

A Okay.

Q -- in my mind, something can be the cause without always resulting in the outcome. Okay? I mean, the two -- the two are distinguishable. There is something that occurs which everyone would agree causes an event, assuming that that event occurs.

A Uh-huh.

Q But that you can still have the initial causal factor, but it doesn't manifest itself in the outcome.

A If there's no outcome, then there's no cause.

Q But in 99 other people it does?

A Ninety-nine other people may have had something that happened --

Q Uh-huh.

A -- in association with something. And someone else may have had the same association and no outcome, but I wouldn't be able to list cause or c-a-s -- c-a-u-s-e.

Q Yeah. So in your mind, the cause always results in the outcome, otherwise, it's not a cause at all?

A There isn't any cause without an outcome.

Q Okay. Okay. Let me talk about maternal smoking or environmental tobacco smoke and a decrease in lung function.

A Uh-huh.

Q Such as the reduction of forced expiratory flows. Do you believe that there is any association that exists between maternal smoking or environmental tobacco smoke and decreased lung function?

A I have read some articles that

consider the possibility. And I am not mentioning about asthma, for instance --

Q Right.

A -- or other predisposing respiratory conditions.

Q Correct.

A Where they talk about lung maturation.

Q Uh-huh.

A But I remember a discussion by an allergist and a pulmonologist who felt that that was not something you could consistently label as a -- a consistent factor in lung maturation in a child.

Q So your opinion would be that there is no relationship between maternal smoking or environmental tobacco smoke and decrease in lung function; is that correct?

A From my opinion and individual patients that I know of --

Q Uh-huh.

A -- not having access to pulmonary vital capacity studies and things like that, I cannot say that the children that I know are less able to run fast or participate in physical

activities which would have to do with lung function.

Q Okay. And then lastly, Doctor, does maternal smoking or environmental tobacco smoke exposure increase the risk or incidence of the development of infant or childhood asthma?

A The whole subject of asthma is very interesting, and no one knows the exact cause of asthma. We know that asthma -- generally considered bronchiospasm and wheezing and things like that -- occurs in the presence of many precipitating factors.

I know of children who have asthma whose parents smoke. I know of children whose parents do not smoke. So that -- then there have been articles about asthma and -- and secondhand smoke or environmental smoke. So I would say that it would be listed as a possible and probable precipitating factor in the frequency or instance of asthma in some individuals.

Q Doctor, you have referred back to several times that your opinions are based upon and basically cannot be extended beyond individual analysis, I think, of individual cases; is that correct?

A Statistics are different from individual cases. I am in my office with one patient, you know. And someone would say 35 percent of this and 35 percent of that, but that means that 70 -- you know 65 percent wouldn't be. And so I -- I don't think you can say -- for instance, take a population of children in certain socioeconomic group who have illnesses. I don't think one can say any one associated factor would -- I'm not a statistician. So I couldn't say like that one guy said, 16 percent --

Q Uh-huh.

A -- of sudden infant death is related to maternal smoking, or you could say that 10 percent of children in a certain population have asthma more often when they're exposed to a certain environment.

I'm sure you read the cockroach article, for instance, and the other multiple air quality and environmental factors that are associated with respiratory illnesses.

When I, just as a plain, general pediatrician in my office seeing patients on an individual basis, that's where I develop my feeling about the various factors involved in an

individual patient.

Q And your opinions, as you've expressed them today and in your report, are based solely upon your individual practice and the results of your independent treatment of these individual patients, right?

A My evaluation of the individual patient is from -- based on my experience, clinical experience. It's based on the knowledge that has accumulated over the years and reading and journals and conferences.

Q Well, would you agree with me, though, that there are numerous studies and people who have done research from a statistical standpoint --

A Uh-huh.

Q -- which you've said several times you're not a statistician -- who have reached conclusions showing that maternal smoking and environmental tobacco smoke have relationships to all these -- these issues of respiratory illness and asthma predisposition and decreased lung function?

I mean, there are those people out there -- I mean, as I understand you're telling me

is that you don't -- you're not aware of their existence?

A No, I'm very aware of their existence. I go to conferences, I read articles. And I have not disputed the fact that environmental tobacco smoke has to be considered an associated factor in these illnesses where it fits in an individual case.

Like statistics, if you take 20 students and 10 of them score a hundred on an exam and 10 of them score a 50, then the class average is 75. So if everyone gets a C in the class, that would be statistically appropriate.

But when I have an individual child, I know of articles, I know of instances, I know of associated factors. So I try to apply that to the individual patient. So if you have a hundred kids in Medicaid or in higher income or a day care or home based and there's different factors in there, how can you determine that 15 percent of it is due to any one thing or 10 percent is due to any one thing? I wouldn't be able to make a statement like that.

Q And I guess in this case, if, in fact, you are not able to individually review the entire

history of Medicaid entitlement recipients --

A Uh-huh.

Q -- in this area --

A Uh-huh.

Q -- which I think both of us would agree this would be a daunting undertaking --

A True.

Q -- given the history and the number of tobacco -- the cases involved, is it my understanding you would not be in a position then to statistically then opine as to what percentage of that population has suffered a poor outcome or suffered an illness associated with maternal smoking or environmental tobacco smoke?

A I would not be able to give a statistical opinion about the percentage or the degree of risk factor of any one agent --

Q Okay.

A -- in a population related to respiratory illnesses.

Q Your analysis would require an individual assessment of the case; is that a fair statement?

A I think in order to make a judgment of anything about an individual child, you have to

have an assessment in an individual case.

Q Okay. Doctor, what is -- and correct me if I misstate this. But what is otitis media?

A Otitis media -- otitis is an inflammation of the ear. And media refers to the middle ear, the area behind the memorandum tympanum, the eardrum, and the middle ear cavity drained by the eustachian tube, and it contains the three otic bones leading into the inner ear.

Q Okay. Doctor, this is a statement from the 1990 surgeon general's report in which the surgeon general states, "Several studies have shown that children exposed to tobacco smoke in the home are more likely to develop acute otitis media and persistent middle ear effusions. Middle ear disease imposes a substantial burden on the health care system."

Do you agree?

MR. MINTON: I just want to make a statement for the record that we're repeatedly quoting from documents and not giving the doctor a chance to review the document, either in context or with the accompanying verbiage.

MR. BLEVINS: I will consider that to be an objection; although, I understand

how you phrased it, and that's not an appropriate statement to make on the record in my opinion based on the Rules of the Eastern District of Texas, but I understand your point.

MR. MINTON: A person not reviewing the video wouldn't be able to see that from a written transcript.

MR. BLEVINS: That's fine.

Q (By Mr. Blevins) Doctor, my question is --

A Would you read that again, please?

Q Sure. "Several studies have shown that children exposed to tobacco smoke in the homes are more likely to develop acute otitis media and persistent middle ear effusions."

Do you agree or disagree --

A That's a statement. What is it in context with, the entire paragraph on --

Q Otitis media is the most frequent diagnosis made by physicians that care for children. The myringotomy and tube procedure used to treat otitis media in more than 1 million American children each year is the most common minor surgical operation performed under general anesthesia.

A Myringotomy.

Q Yeah. I am just trying to figure out from your standpoint --

A Uh-huh.

Q -- whether or not in your opinion you believe that children exposed to tobacco smoke in the home are more likely to develop acute otitis media and persistent middle ear effusions?

A There are different types of otitis media, of course --

Q Uh-huh.

A -- and different etiologic agents.

Q Uh-huh.

A And the reason for otitis media is an infection by a germ. So that the presence of an irritant in the environment which predisposes them to nasal congestion or anything like that --

Q Uh-huh.

A -- can be an associated factor. But in an individual case, I don't know that -- again, are you -- I cannot make a comment about that statement out of context of what statistics or what data go into the making that one conclusion.

Q Okay. Well, again, my --

A And I'm not trying to evade your

question. I'm also saying that out of context that I can't really say whether I wholeheartedly agree with that. Because in my individual case, again, there are many children who are in homes where there is tobacco smoke who don't have middle ear infections.

Q Okay.

A And there are many kids who have middle ear infections who aren't indicated in the homes where there is. So I can't -- that one statement, I can't agree word for word out of context of whatever the reference is you're using.

Q In your opinion, is either maternal smoking or environmental tobacco smoke in the home a risk factor or associated with the development of otitis media?

A Would you sate that again?

Q Sure. In your opinion --

A Uh-huh.

Q -- put that aside. I'm just asking, in your opinion, is maternal smoking or environmental tobacco smoke a risk factor or associated with the development of otitis media?

A Well, I would say environmental tobacco smoke wouldn't be just maternal, it could

be paternal or grandparents or anybody else.

Q Okay.

A And I can say that we would have to list that as one of the irritants that could cause predisposition to respiratory illnesses of all kinds.

Q And it's the respiratory illness which, I guess, gives rise to -- or increases the incidence of otitis media?

A Yes. When you have otitis media, which is infection of the middle ear, it's usually due to three organisms. The hemophilus influenza, strep pneumo and --

THE REPORTER: And what?

THE WITNESS: Assyria catarrhalis. I can write those down later if you need them.

A So that the pathogenesis of that is that organism has to be present in the nasopharyngeal area. There are many people that can carry that without clinical illness. If they develop a viral infection, such as a rhino virus or some viral illness, then that may decrease their resistance to an organism. And that organism then propagates in the nasopharynx and

then can go up the eustachian tube into the middle ear and result in otitis media.

Q (By Mr. Belvins) Okay.

A That's the pathogenesis of the disease.

Q Okay. Doctor, I had previously provided you with the American Heart Association document as an exhibit to your deposition. It's right in front you. You're looking -- that's the surgeon general's report. I'm talking about this article right here.

A Here we are. All right.

Q Yes. And we had talked first about the potential definitional use of "addiction." And I would like to direct your attention to the third page, Page 2583.

A 2583?

Q Yes.

A Lists respiratory morbidity?

Q Correct. And what I am trying to do is -- obviously, the American Heart Association, I believe, through this article, has reviewed and at least referenced some 141 different references throughout --

A Uh-huh.

Q -- for the basis of certain conclusions that are found at Page 2583. And I will tell you right now that I do not have the copies of all 141 references, nor would I -- nor do I think you or I either one would want to go through all 141 of them today.

A Uh-huh.

Q But, actually, what I'm trying to find out is whether generally you agree or disagree in your own personal experience with some of the statements that are made by the American Heart Association here.

A Right.

Q Okay?

A Uh-huh.

Q And this article will be attached as part of your deposition, and you will have an opportunity to go back and look at any of the references, you know, prior to trial that you would care to.

A Uh-huh, all right. Thank you.

Q First of all, would you agree or disagree that tobacco smoke and its products affect the lungs and respiratory tracts of infants, children, and adolescents by passive

exposure in utero caused by maternal smoking?

A Where is that sentence?

Q I'm sorry. Very first sentence under respiratory morbidity. And I should say by passive exposure produced by the parents or caretakers or by active exposure caused by smoking tobacco products. That's the entirety of first sentence.

Do you agree or disagree with that sentence, Doctor?

A I think the -- you're talking about that entire first sentence?

Q Yes, sir.

A Affects the lung and respiratory tracts of infants by passive exposure in utero caused by maternal smoking?

Q And it also goes on to say, and by passive exposure to tobacco smoke produced by parents and caretakers or by active exposure caused by smoking tobacco products. That's the entire sentence.

A Yeah. I can't say that the lungs and respiratory tract of children are -- and adolescents are affected by passive exposure in utero.

Q Okay. Do you agree that they are affected by passive exposure to tobacco smoke produced by parents and caretakers?

A I can agree and have no argument with a statement that would say tobacco smoke may affect the lungs and respiratory tract of infants, children, and adolescents.

Q Okay.

A By passive exposure, may, by passive exposure.

Q All right. Go down to the --

A Or by active exposure.

Q All right. Go down to the third paragraph, which begins with, "respiratory infections."

A Uh-huh.

Q Do you agree or -- there's several sentences here. And I will read the first introductory sentence. Respiratory infections are frequent in childhood and about 30 percent of all infants are treated by a physician for bronchitis -- or actually bronchiolitis?

A Bronchiolitis.

Q -- bronchiolitis, croup, or pneumonia. Risk of respiratory illness is

increased in infants and children whose parents smoke.

Do you agree with that statement?

A If you emphasize risk of respiratory illness in children is increased whose parents smoke, I would have not -- I would have no argument with that sentence. The first sentence, I don't know where the 30 percent comes from. So I couldn't agree with everything in there.

Q Okay.

A But I think your -- your statement that risk is increased in some infants and children whose parents smoke, I would agree to that modification.

Q All right. The next sentence reads, "Infants exposed to maternal smoking had an increased incidence of lower respiratory tract infection."

Is that something that you have seen in your own practice?

A Some infants exposed to maternal smoking, other factors being the same --

Q Okay.

A -- may have an increased incidence of lower respiratory infection.

Q It goes on to say that this effect shows a dose-response relationship to maternal smoking and decreased after the first year of life. Infants with bronchiolitis before the age of two years were 2.4 times more likely to have been exposed to maternal smoking than infants who did not develop a lower respiratory tract infection.

Were you aware that there at least were those conclusions or those type of opinions in the medical community?

A I see it does cite a reference here that you and I are neither familiar with in its entirety.

Q If I understand -- I'm sorry.

A I would not -- I would not have a specific argument with this statement based on what I know now.

Q Uh-huh.

A Although, as I said, I do not have all the information that made that statement a conclusion.

Q Okay. Let me get you to move over to the right-hand column and the fourth paragraph beginning with asthma.

A All right.

Q Okay. There are some introductory sentences in regards to, "Asthma is a leading chronic childhood illness in the United States."

A Uh-huh.

Q "Morbidity and mortality due to asthma have increased in recent years, particularly in children."

A Uh-huh.

Q Then it says, "Exposure to environmental tobacco smoke in children is associated with an increased risk for developing asthma among certain children at risk."

Is that a statement that you would --

A I have no argument with that.

Q All right.

A The emphasis being "among certain children at risk."

Q Okay. "Children aged zero to five years who are exposed to maternal smoking are 2.1 times more likely to develop asthma compared with those free from exposure. Risk of asthma is 2.5 times higher in children exposed to maternal smoking when the mother has less than 12 years of education."

A That's an interesting statement, isn't it, that education is a cause of asthma?

Q Well --

A Or is associated with asthma.

Q Is it your understanding or would you agree with me that the percentage -- the highest percentage -- well, strike that.

That the one area of increased smoking in the United States is in younger and less educated -- is in the younger and less educated population?

A That there is more use of tobacco products?

Q Tobacco products and that actually tobacco products are on the increase in that group.

A Is that right? I don't know that. I would not be able to give an opinion about that.

Q Would it surprise you to find that mothers who have less than 12 years of education have a higher incidence of smoking than do mothers with more than 12 years of education?

A I wouldn't be surprised, but I don't know. Are there some data that you have about that?

Q Doctor, there has been several reports in a lot of different areas.

A Uh-huh.

Q But that's -- that's my understanding of why they put that educational aspect --

A Okay.

Q -- into the asthma, because there was a relationship to smoking.

A I accept your knowledge in that area.

Q Do you agree with the fact that children aged zero to five years that are exposed to maternal smoking are 2.1 times more likely to develop asthma compared with those free from exposure?

A That's a statistical conclusion, and I don't have the whole report. So I wouldn't know about 2.1 or 2.5. And as you know, women -- mothers who have less than 12 years of education tend to be in a -- an environment, and the children tend to be in an environment where there are a lot of other risk factors involved compared to people who have parents over 12 years of education. So --

Q And that would be based upon what additional factors? I mean, what factor --

A Socioeconomic.

Q Okay. Basically, that they are poorer?

A Children of mothers who have less than 12 years of education probably are in a lower socioeconomic group than those with more than 12 years of education. It would probably be more likely to be in a day care situation or inadequate child care situation. Probably be exposed to more risk factors of all kinds for respiratory illnesses.

Q Okay. Solely --

A Because --

Q Those are the two factors that you consider as being the low socio -- low socioeconomic factors are child care issues? Is that -- is that your -- your risk factor analysis for low socioeconomic --

A You mean child care factors?

Q Yeah. In other words, you said that the lower socioeconomic status of women who have less than 12 years of education manifests itself in, as I understood it, less desirable child care scenarios, I mean, they are in day care, they have inadequate care during the day, I assume?

A Well, I'm saying that in regard to respiratory illnesses in children, that the various risk factors are associated factors in regard to respiratory illnesses may be more prevalent in lower socioeconomic situation -- environment.

Q And I'm asking you, what is it specifically about the lower socioeconomic environment that you think puts these children at greater risk?

A Several things in my experience in working with the population and teaching capacity at Children's Medical Center outpatient and in my own clinical practice. One would be the -- as I say, the child care situations, in the home or a care givers.

Q Uh-huh.

A The decrease in medical care, particularly preventive care, the -- probably the poor air quality as far as irritants in the air, you know. You are familiar with studies about air quality in the homes, overcrowding. All of those factors contribute to increased incidence. Inaccurate seeking of medical care, poor preventive care, less desirable child care

situations, increased incidence of neglect and abuse.

Q Does that finish off your list?

A That's an answer.

Q Okay. Doctor, are you familiar with the American Academy of Pediatrics' tobacco -- Committee on Substance Abuse and its statement of a tobacco-free environment and imperative for the health of children and adolescents?

A I haven't read that report word for word. I appreciate your giving it to me.

Q Okay. I would like to go over a few areas here and see if these are any sort of a revelation or surprise to you.

You will note in the first paragraph, it starts off with, "Smoking is the leading cause of preventable death in the United States. It is responsible for approximately 20 percent of deaths annually. And environmental tobacco smoke is estimated to cause 3,000 lung cancer deaths per year in nonsmoking Americans."

A Again, we are talking about causes versus associated factors and things like that. So aside from quibbling about the definition of cause and things like this, this is a statistical

statement that was made.

Q Okay.

A I have not made any study to refute this lead sentence.

Q "It is also estimated that the" -- continuing on.

A Uh-huh.

Q "It is also estimated that the elimination of smoking would reduce infant deaths by 10 percent and decrease the incidence of low birth weight infants by 25 percent."

A That's a statement that was made on the basis of statistical data.

Q Okay. So, again, you wouldn't have anything to --

A I wouldn't have an opinion to the contrary --

Q Okay. Does it --

A -- not having seen this report or any of the other data on which its based.

Q Based upon your knowledge generally, does that type of statement from the American Academy of Pediatrics surprise you? I mean, is that shocking to you in terms of the numbers that they're quoting or the percentages that they are

attributing to maternal smoking or environmental tobacco smoke?

A This isn't a statement from the American Academy of Pediatrics. It's a statement by one group of one committee --

Q Okay.

A -- making statements based on some statistical data that they've had. It doesn't surprise me or shock me, no.

Q Tell me what your feeling is, your opinion is in regards to -- obviously, the Committee on Substance Abuse is a committee that is appointed and put together by the American Academy of Pediatrics; is that correct?

A Committee members are appointed by the president and the board, yes.

Q And I assume that that committee is given some form of general directive on what -- what they are supposed to review and produce a statement on. And that's done on behalf of the American Academy of Pediatrics. I mean, obviously the academy has to separate and review different issues. And so these committees are then responsible for making a statement that is applicable to the academy as a whole. I mean, is

that a fair statement?

A It's not applicable to each member of the academy.

Q No, I agree.

A It is a statement that is developed by this group who has a charge, as you say --

Q Uh-huh.

A -- to render an opinion. And then that can be adopted by the board of the Academy of Pediatrics.

Q When the --

A So as a member of the American Academy of Pediatrics, I don't agree with everything that comes out from that.

Q I understand.

A But it is a consensus that the American Academy of Pediatrics' hierarchy agrees to be issued for information.

Q And when it comes out, when it actually goes into print --

A Uh-huh.

Q -- that means that it has been adopted by the American Academy of Pediatrics; is that correct?

A By the boards?

Q Right.
A That they have agreed to have that by the board of the American Academy of Pediatrics, uh-huh.
Q Okay. Okay. If you'll go down about four sentences up from the bottom of that first section on background --
A Uh-huh.
Q -- you will find the reference that I was speaking to you about before in which it says "Smoking rates are twice as high for those who do not complete high school as compared with those who graduate from college."
And that gets back to that educational issue.
A Yeah.
Q And that's where I got that reference from or had that opinion derived from.
A Uh-huh.
Q Just wanted to let you know.
A Thank you.
Q Okay. Next under Perinatal Hazards, the community on substance abuse, the American Academy of Pediatrics states, "Smoking during pregnancy has been associated with certain

childhood cancers. It doubles the likelihood of bearing an infant with intrauterine growth retardation. And it increases the risk of spontaneous abortion, premature rupture of the membranes, and delivery of a stillborn infant."

Is that consistent with your knowledge and understanding of those areas?

A The operate words is "has been associated"?

Q Correct.

A In conjunction with all the other factors, too?

Q Right.

A With the operate words being "has been associated," I don't have any data to refute that statement.

Q Okay.

A Uh-huh.

Q Does the next sentence accurately reflect your opinion on sudden infant death, which is, "Both intrauterine exposure to tobacco smoke and passive inhalation by the infant seem to be associated with increased risk of sudden infant death syndrome"?

A The operate word there is "seems" --

Q Correct.

A -- which means that it's very vague there as far as the significance of it. So I think that that is a very wishy-washy sentence. And so I would not have any objection to a wishy-washy sentence with "seems."

Q Basically, it's kind of what you said about it yourself?

A On --

Q On sudden infant death syndrome?

A That there are multiplicity of factors and the percentage of significance of the factors are constantly changing --

Q Okay.

A -- in the area of sudden infant death, yes, sir.

Q All right. Now, and then in the area, we have Childhood Complications of Exposure to Environmental Tobacco Smoke. See if this basically is in agreement with your opinions today.

"Children exposed to cigarette smoke, especially from birth to two years of age, have an increased risk of a variety of medical disorders. They exhibit increased incidence of upper

respiratory tract infections, middle ear effusions, allergic complications, and impairment of pulmonary function, problems that exhibit a dose-response relationship."

A With what? Dose-response relationship with what?

Q Well, the first part is dealing with cigarette smoking. So I'm assuming a dose-response relationship between cigarettes and upper respiratory tract infections, middle ear effusion, allergic complications, and impairment of pulmonary function.

A There's several references there. I would not right at this moment argue with that statement. But as far as the significance of that in relation to decrease in passive immunity from the child, the other associated factors regarding the respiratory illnesses and things like that, I don't say -- I don't know exactly where they exhibit a dose related relationship.

Q Okay.

A Whether the mother -- you're talking about whether the mother smokes two cigarettes a day or four cigarettes a day or whether both parents smoke or whether it's all the time or just

evenings. A dose related relationship to me doesn't -- I can't envision exactly what they mean by that.

Q Okay.

A But I think, as I have said before several times, that I have to consider -- I do consider the presence of environmental tobacco smoke in an environment of particularly your own child an associated factor in some children as far as respiratory illness. So I repeat what we've said several times before.

Q Okay.

MS. LEWIS: Do you have extra copies of all those?

MR. BLEVINS: There's going to be copies attached to the deposition. That's the only ones that I have. Yeah.

These, however, have been utilized in every deposition so far. I mean there's copies to -- each one that has been at each deposition.

Q (By Mr. Blevins) Why don't we take a quick break. And, Doctor, if you would, during the break, I would ask that you look through the articles that we've marked and attached as

Exhibit 10, this group here.

A Uh-huh.

Q Because the question that I'm going to want to know is, I'm going to need you to identify those documents for us so that we know what's part of Exhibit 10 --

A Uh-huh.

Q -- and then, to the extent that any of those articles stood out to you or there's any significance that you found in them that's relative to your testimony today, I would like for you to be able to tell me that to the extent that by looking at them you recognize that.

I know your initial opinion was that they didn't really form any part of your opinion. I wanted you to refresh your recollection.

A Would you say that by reading those articles some of the statements made concur with my opinion?

Q I'm really not looking for things that simply concurred with your current -- your previous opinions.

A Yeah.

Q I'm looking for something that may have changed or modified any opinion that you had

previously.

A Okay.

Q Okay?

A I will look over them and then make the statement that I made before --

Q Okay.

A -- that nothing in there has changed my opinion.

MR. BLEVINS: Let's take a quick break, and I think we're headed down the homestretch.

THE VIDEOGRAPHER: We're off the video record.

(A recess was taken.)

THE VIDEOGRAPHER: We're on the video record.

Q (By Mr. Blevins) Doctor, we have marked as Exhibit 10 to your deposition the articles provided to you by the lawyers for the tobacco companies, which as I understand it are the only specific articles that you've collected and reviewed for your testimony today. That is, not including your past history of reading journals and articles in your practice; is that --

A That's correct.

Q Okay. Doctor, if you would, please identify each article that is included in Exhibit 10 and please tell me whether or not any of these articles held specific or special significance to you in either the changing or modifying the opinions that you had prior to being contacted to testify in this case.

A Prior to being asked to testify?

Q Right.

A Do you mean prior to my first phone call from Dr. Cole?

Q Correct.

A Okay. None of these articles were articles that I had read or recall prior to my contact with Dr. Cole.

Is that what you are --

Q Yeah. In other words, after you received these articles and you reviewed them, did any of them change or modify the opinions that you had regarding smoking and infant diseases that you had prior to being contacted?

A I see. No. None of these articles changed or modified my opinions.

Q All right. And could you just briefly for the record identify the articles that are

contained in Exhibit 10?

A I will. There's an article from Indoor Environment, selected abstracts of the satellite symposium Indoor Air Quality in Asia. An article from a journal, Indoor Environment, Selected Abstracts on Priorities for Indoor Air, Research and Action. A clinical tutorial with a summary of articles regarding Smoking and Middle Ear Disease, Are They Related, a review article. An article Environmental Tobacco Smoke, Proceedings of the International Symposium in 1989 in which there are multiple abstracts regarding environmental tobacco smoke.

This is an article, Does Environmental Tobacco Smoke Cause Adverse Health Effects in Susceptible Individuals, a Critical Review.

A facsimile report, United States Department of Energy, having to do with a 1987 summary or proceedings of a conference on indoor air quality and climate.

There is an article on the effect of cockroach allergy and exposure in cockroach allergin causing morbidity among inner city children with asthma.

Commentary, Wrong Turns in Sudden

Infant Death Syndrome Research, an article about some of the assumptions that are no longer valid in sudden infant death syndrome with newer information available.

And another one on crib death, which is sometimes used interchangeably with sudden infant death and managed care.

Q Okay. Doctor, I would now like to refer you back to your report marked as Exhibit 1 to your deposition.

A Uh-huh.

Q I just want to make sure, I think we've covered almost all the opinions that are expressed within the report. We have probably covered them in some detail throughout the deposition.

A Uh-huh.

Q I want to be clear about a couple of areas. In the second paragraph under risk factors for childhood diseases on the first page, does the list of risk factors found in the last sentence accurately reflect the predominant amount of risk factors you consider important in the Medicaid population as it relates to these areas?

A The statement is, in general -- these

risk factors include poor housing conditions, crowded living situations, poor indoor air quality, lower educational level, younger maternal age, risky life-style behavior such as drug and alcohol abuse, poorer diet, poorer access to health care, and the lack of understanding about and/or compliance with appropriate medical advice. These are inclusive of most of the factors, particularly, as you say, poor housing conditions, which would include in the cockroach article, a dead and decaying cockroach causing allergic reactions, dust mites.

Q Doctor, do you have an opinion about whether or not a risk level such as lower educational level may have a corresponding higher incidence of smoking? In other words, those persons with lower educational level have, also, an increased incidence of smoking?

A You pointed out a sentence in one of your earlier studies suggesting that tobacco smoking was more prevalent in the lower socioeconomic. I accept that statement.

Q Okay. I guess from my standpoint, have you, in your mind, differentiated between these risk factors and their inherent -- in some

of them at least, their inherent association with smoking itself?

A I would say that the more risk factors that are in an environment, the less percentage significance there would be of environmental tobacco smoke. If you have a clean house and someone smokes, that's different from living in a house with 10 other kids and a dirty environment and dead and decaying cockroaches and indoor space heaters with the gas heaters producing carbon monoxide and everything else. So that the percentage significance of any one factor would be even less if there are multiple contributing factors.

Q Okay. But, my question would be, have you satisfied yourself that these risk factors have been sufficiently separately studied as opposed to those risk factors which may have an increased association with smoking --

A I don't know --

Q -- such as the low educational level?

A For instance, you're talking about tobacco smoking and cockroach allergy or tobacco smoking and the number of children in the family, or tobacco smoking and the type of

air-conditioning or lack of such or heating? I haven't read articles having a dichotomy or a pairing of environmental tobacco smoke with each of these other risk factors, no, sir.

Q In your opinion, do -- have -- are cigarettes and tobacco smoking generally associated as a gateway to other drugs, such as alcohol or marijuana or cocaine use?

A This is outside the scope of our reason for the deposition. But there are studies that suggest that tobacco smoking is a -- an event that occurs in many children or people before they use other drugs --

Q Okay.

A -- such as alcohol, marijuana, and other drugs.

Q Okay. Under your description of otitis media on Page 1, you do not list smoking, environmental tobacco smoke, or maternal smoking as even a risk factor or association for otitis media. And I'm just try trying to make sure summarily today --

A Uh-huh.

Q I thought that we had discussed in your deposition that maternal smoking would at

least be one of the things that you would consider in an otitis media case and, thus, it is a risk factor or association with otitis media?

A Yes. That statement, I did not list everything -- the statement you're alluding to is one of the strongest risk factors for otitis risk factor is exposure to numerous other children, including either multiple siblings in a household or day care centers.

So that's the one positive statement of one of the -- I did not list all the other associated ones that could be, as I say, cockroaches or poor air quality.

Q But in terms of your statements with otitis media and then asthma, I believe the pediatric respiratory condition and SIDS, while you may believe that there are more prominent risk factors and associations, you would at a minimum agree that maternal smoking is a risk factor or association for each of those?

A I don't like to use the term "maternal smoking." I think exposure to any environmental tobacco smoke has to be listed as one of the possible risk factors in respiratory illnesses, yes.

Q Okay. Doctor, in your testimony in this case, have you reached any conclusions about the specific amount of money in which the State of Texas has spent or may have to spend in the treatment of these respiratory illnesses in the Medicaid population?

A I have not -- I have read and followed articles in the paper, but I don't know of any specific amount that the State is suggesting. I do not know specific money amounts that are involved.

Q Have you been asked by the tobacco industry through the defense lawyers to estimate that amount or to create some form of model or some form of equation that could be applied --

A Uh-huh.

Q -- and I assume that this would involve some statistical analysis --

A Uh-huh.

Q -- to generate such a dollar amount or percentages?

A No. I haven't been asked by them. I would presume that that would be done by the plaintiffs in trying to determine what their request for reimbursement would be.

Q Now, if I understand how you have based your opinions, it would really -- to try to do that would be inconsistent with your fundamental basis of opinions, which as I understand it, requires a more individualized evaluation of a particular case? Is that a fair statement?

A Where I come from, as an individual patient -- doctor treating individual instances, my opinions have evolved from that, from my clinical experience and my reading, judgments. So that I would not feel that I would be qualified in any way to develop a statistical model or say that any one factor would be a percentage of significance in a population.

Q Okay. Based upon our deposition today and the various topics that we've addressed, do you, as you sit here today, plan on doing any additional research or literature search prior to testifying in this case at trial?

A No. My opinions all during this are no different than the ones that were there before I even talked to Dr. Cole.

Q Okay.

A They are not going to change

subsequent to this, either.

Q Based upon what we've done today, do you anticipate requesting any additional information on any particular topics from the tobacco companies?

A No. As I see my particular contribution, if any, it's listed in this statement, as a general pediatrician and my clinical experience and these particular areas.

Q Okay. Doctor, when you treat a patient that comes to you through the course of your practice, do you know whether or not that patient is on Medicaid?

A Yes, we do. We know which ones on are Medicaid, because each Medicaid patient has a -- you know, has a register. We know whether they're insurance, not insurance, if they're Medicaid, or what their particular situation is.

Q Whether that --

A And each Medicaid patient has a separate form to be submitted after an office visit.

Q When -- I'm sorry.

Whether that patient is on Medicaid or not, does that actually change your treatment

program or care for that particular patient?

A It does not affect my diagnosis or treatment or caring for that patient, their financial status is not a factor in my care. The only variable would be some of the pharmaceutical companies supply us with samples of medications and things like that. And many times we reserve those for the people who are less able to pay for medication. So that would be a variable, but not in the diagnosis suggested for treatment or the care.

MR. BLEVINS: Okay. Doctor, I believe that's all the questions that I have for you today.

THE WITNESS: All right, sir.

MR. BLEVINS: The plaintiffs will withdraw Exhibits 8 and 9 from the deposition. Neither article or exhibit was utilized during the deposition nor was it identified in the deposition.

MR. MINTON: Okay. I just have one quick question or two.

EXAMINATION

BY MR. MINTON:

Q Doctor, Mr. Blevins on a couple of

occasions -- on many occasions used the phrase "risk factors" or "associated factor." And then I believe on one or two occasions dropped the "risk" or "associated" and simply used the word "factor."

When he used the word "factor," did you understand him to mean "risk factor" or "associated factor"?

A In the context of our discussion, I assumed that that was equivalent.

MR. MINTON: I didn't think there would be any dispute about that. I just wanted to clear it up.

That's the only question I had. Thanks.

MR. BLEVINS: All right.

MR. MINTON: We will read and sign.

THE WITNESS: Appreciate your conversation.

MR. BLEVINS: Thank you.

THE VIDEOGRAPHER: We're off the video record.

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STATE OF TEXAS

COUNTY OF DALLAS

I, AMY DOMAN, a Certified Shorthand Reporter duly commissioned and qualified in and for the State of Texas, do hereby certify that there came before me on the 25th day of July, 1997, in the offices of Jones, Day, Reavis & Pogue, located at 2001 Ross Avenue, 2300 Trammell Crow Center, in the City of Dallas, State of Texas the following named person, to-wit: **PERCY E. LUECKE, JR., M.D.**, who was duly sworn to testify the truth, the whole truth, and nothing but the truth of knowledge touching and concerning the matters in controversy in this cause; and that he was thereupon examined upon his oath and his examination reduced to typewriting under my supervision; that the deposition is a true record of the testimony given by the witness, and signature of witness is to be before any notary public.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney